family medical care

Downloaded from Fountain of Knowledge Library

R. A. MUJAHID BALUCH

Downloaded from Fountain of Knowledge Library

B. A. MUJAHID BALUCH

family medical care

VOLUME 1

CREATIVE PARTNERSHIPS

Downloaded from Fountain of Knowledge Library

OTHER BOOKS BY THE SAME AUTHOR INCLUDE:

Everything a Teenage Boy Should Know
Everything a Teenage Girl Should Know
Everything a Married Couple Should Know
Everything a Growing Child Should Know

Downloaded from Fountain of Knowledge Library

VOLUME 1

family medical care

A four-volume illustrated series covering all aspects of health care

JOHN F. KNIGHT
M.B., B.S. (SYD.)

Incorporating the assistance of more than fifty medical and paramedical specialists

B. A. MUJAHID BALUCH

Signs Publishing Company, Warburton, Victoria, Australia

Copyright © 1982 by
Dr. John F. Knight, M.B., B.S. (Syd.)
and Dr. James Wright Features

Revised and reprinted 1984.

Downloaded from Fountain of Knowledge Library

ISBN 0 949809 00 4 (Set of four volumes)
ISBN 0 949809 01 2 (Vol. 1)

Downloaded from Fountain of Knowledge Library

contents

Volume 1—Creative Partnerships

SECTION 1—All About Marriage

1. Just Married: "Getting to Know You" 13
2. Setting up a New Home 18
3. Baby Days and Boys and Girls 25
4. Marriage and Finances 30
5. The Social Aspects of Marriage 36
6. The Sexual Aspect of Marriage 43
7. All About Family Planning 50
8. The Key Reasons Why Marriages Fail 59

SECTION 2—Pregnancy and Reproduction

1. How Do I Know I Am Pregnant? 65
2. Adequate Medical Care Is Essential 70
3. The Practical Benefits of Correct Thinking 79
4. Sensible Care Pays Off 83
5. There Are Certain Risks. Beware! 88
6. Watch Your Weight When You Are Pregnant 95
7. Sensible Eating Pays Off 98
8. Annoying Problems That Occur During Pregnancy 101
9. Things That Can Go Wrong and How They Are Corrected 107
10. Termination of Pregnancy 115
11. The Exciting Happenings of Pregnancy 120
12. Baby Arrives! 131

SECTION 3—Baby Days and the Growing Child

A guide to child-care from the moment he arrives home from hospital until he starts to grow up and develop into a happy, intelligent member of the family unit. 135

An alphabetical check-list enables immediate reference to all major and minor problems. 137

Volume 2—Major Systems of the Body, and Emergencies

SECTION 4—The Heart and Blood-Vessel System

The Incredible Machine That Never Stops Working - Heart Attack! - How to Avoid a Heart Attack - How to Recognise a Heart Attack and What to Do - All About Angina - The Problem of Elevated Blood Pressure and How It Is Treated - Heart Failure - Irregularities of the Heartbeat - Cigarette Smoking: the Present Position - Congenital Heart Defects - Disorders of the Heart Valves - Disorders of the Blood-Vessels.

Downloaded from Fountain of Knowledge Library

SECTION 5—The Breathing Apparatus

How the Machine Works - The Common Cold and Upper Respiratory Tract Infections - Sinusitis, Nose Bleed, Hay Fever, and Laryngitis - Acute Bronchitis, Chronic Bronchitis, Emphysema - Bronchial Asthma - Pneumonia - Lung Cancer - Tuberculosis - Pleurisy and Disorders of the Lung - Other Lung Disorders.

SECTION 6—Emergency First Aid

Introduction: What to Do in an Emergency - The Emergency First-Aid Kit - Emergency Treatments.

SECTION 7—The Food System

How the Gastrointestinal System Operates - Disorders of the Oral Cavity, Tongue and Salivary Glands - Treating Throat Disorders: Tonsillitis (and Quinsy); Pharyngitis (Sore Throats) - Disorders of the Oesophagus (Gullet): Oesophageal Cancer and Hiatus Hernia - The Stomach and Duodenum: Gastritis, Peptic Ulcers, Cancer, Pyloric Stenosis - Other Disorders of the Gastrointestinal System - Disorders of the Liver, Gall-Bladder and Pancreas.

Volume 3—Marvels of the Human Frame

SECTION 8—Strictly Feminine

All About the Normal Me - Monthly Problem Time - Menstrual Irregularities - Feminine Irritations - Cancer of the Uterus - All About the Change of Life - Things That Go Wrong in the Pelvis - Why Can't I Become Pregnant? - Facial Hair . . . and What to Do - Breast Cancer - Love-making and Some of the Problems - The Sagging Womb and Bladder Problems.

SECTION 9—The Communication System

How the System Operates - Altered Consciousness - Blood-Vessel Disorders of the Brain - Headaches and How to Treat Them - Abnormal Movements - Infections of the Brain and Nervous System - Growths of the Head - Degenerative Nervous Diseases - Speech Disorders - Other Disorders of the Nervous System.

SECTION 10—Disposing of the Waste Products

Introduction: This Is the Renal System - Urinary Tract Infections (Including Analgesic Renal Disease) - The Renal System: Glomerulonephritis - Kidney Stones and Bladder Stones and Associated Pain - Kidney Transplants and Renal Dialysis - How to Cure the Bed-wetters - Cancers of the Bladder and Kidney - For Men Only: Prostate Problems.

SECTION 11—The Transport Operation

What the Blood Is All About - Haemorrhagic Disorders: Haemophilia and Christmas Disease - Bleeding from Drug Overuse - The Purpuras (Bruising) - The Anaemias: Iron Deficiency Anaemia - Vitamin B_{12} and Folic Acid Deficiency - Anaemia - Aplastic Anaemia - Cancer of the Blood System: The Leukaemias - Hodgkin's Disease and the Lymphomas - Miscellaneous Disorders of the Blood and Lymph Systems: Infectious Mononucleosis (Glandular Fever) - Leucocytosis and Leucopenia - Lymphadenopathy - The Haemoglobinopathies: Sickle-cell Anaemia - Thalassaemia.

Downloaded from Fountain of Knowledge Library

SECTION 12—The Internal Gland System

Introduction. What Are the Endocrine Glands? - Pituitary Gland: Captain of the Ship - Thyroid Gland: It Overworks and Underworks - The Parathyroids: Calcium and Phosphorus Care - The Adrenal Glands: Bizarre Symptoms Possible - The Gonads: All About Male and Female Sex Glands - Diabetes Mellitus (Sugar Diabetes): Affects 13 per 1,000.

Volume 4—Special Organs and the Skeletal Structure

SECTION 13—Special Organs: The Eye; The Ear, Nose and Throat; The Skin

THE EYE

Introduction: How It Works - Disorders of the Eyelids, Lachrymal (tear) Apparatus, and External Areas of the Face - Disorders of the Conjunctiva and Cornea - Disorders of the Iris, Lens, Vitreous, Retina and Eyeballs.

THE EAR, NOSE AND THROAT

General Discussion - Disorders of the Ear: The External Ear - Disorders of the Ear: The Inner Ear - Disorders of the Nose - Disorders of the Throat (Pharynx) - Disorders of the Throat (Larynx).

THE SKIN

Skin Disorders: Introduction - Bacterial Skin Infections - Viral Skin Infections - Parasitic Skin Infections - Sebaceous Gland Disorders - Sweat Gland Disorders - Dermatitis and Eczema - Fungus Infections of the Skin - Tumours of the Skin - Other Skin Disorders - All About the Hair.

SECTION 14—The Movement Apparatus

Introduction - Rheumatoid Arthritis and Allied Disorders - Osteo-Arthritis and Ankylosing Spondylitis - The Agony of Gout and How It May Be Cured - Diseases of the Bones: Osteoporosis - Osteomalacia (and Rickets) - Osteitis Deformans (Paget's Disease) - Osteomyelitis - Bone Tumours.

SECTION 15—Home Treatments

Home Therapy That Never Fails (Mostly Free) - All About the Vitamins - How to Go to Sleep at Night - Hydrotherapy and Massage: Simple Drug-free Home Therapy - Cancer: Heed the Early Warning Symptoms - Overweight and How It Is Treated - How to Cure the Underweight - A Word to the Aged. Parting Advice.

SECTION 16—Family Health and Immunisation Charts, Transvision Plates of the Human Anatomy, and General Index

Downloaded from Fountain of Knowledge Library

This Book Is For You . . .

"Are these symptoms serious?"

"What is the significance of that ache, pain, strange feeling?"

"What kind of treatment will the doctor prescribe?"

"Could this be cancer? Cancer kills. Will this kill me?"

"I didn't realise early marriage had so many problems!"

"How can I keep fit and well during my pregnancy, and what will it be like? What happens inside before baby comes?"

"Childhood problems. I wish I knew what to do without having to race off to the doctor's every time something goes wrong, especially as he says, 'Don't worry. It is not serious.' But how am I to know?"

"Old age has problems. I didn't realise that so many things could happen."

These questions, and millions like them, are asked every day. Comments are made, opinions given.

Today, everybody is aware of illness, and is taking a greater and greater interest in how it occurs, how it is diagnosed. And what is even more important, how it can be cured. Preferably, quickly.

Lots of sensible-thinking people also take the long-term view. If the last illness was a terrible experience, then what can be done to prevent recurrences? Or better still, how can illness in general be stopped before it starts? Preventive medicine is the technical word, and it can apply effectively at the home level.

That's what these books are all about. They are intended to be a multi-purpose manual geared for use by every intelligent member of the family.

It is hoped that the books will contain something of value for every age group, and in this way cope with medical care right from conception. Or as one of my friends jocularly put it: "Medical care . . . from the womb to the tomb."

The volumes have been prepared in sections, each covering a relevant segment of time, or of the community. A quick run down the list of contents will soon indicate that the net has been cast as widely as possible.

"What Did He Mean?"

An effort has been made to present the material in understandable language. Too many patients leave the doctor's surgery having heard a lot of words, many of them being incomprehensible. It is not always the doctor's fault, for many technical words are not easily translated.

However, minimum use of hard-to-understand words and phrases has been made. If it is necessary to use them, explanations are often given to make their meaning clearer. So, whereas this is basically a technical book, everyday language is the rule; therefore I feel that practically everybody will readily comprehend the meaning in virtually every section.

Downloaded from Fountain of Knowledge Library

Some parts have been written in a more easy-going manner, and this is to bring us all together on a friendly level. Getting to know you is important, and whenever the occasion makes this possible, it has been taken advantage of. Some parts, due to their very nature, have to be a little bit more distant. But often simple illustrations and stories have been included to push a point home. There is nothing like a practical example from real life to make a message clear, I feel.

Of course, some will say that the book is inadequate and does not contain every known thing about every known medical subject. I would agree with this comment.

However, the range of medical knowledge, just as with all technical subjects at present, is still increasing with enormous rapidity. I know this only too well, for I have kept a medical filing system into which I personally feed new data as it comes to hand. This is usually in the form of about six world-wide medical journals a week, plus the abstracts from another fifty specialty medical journals, also weekly. It takes a lot of time, every day of my life. I find this is necessary in order to keep up to date with the broad tenor of medical advances. But it is also vital in keeping up to date with the numerous writing commitments I carry out regularly for national and international media services.

I Have Been Selective

To contain the book into manageable proportions, it has been necessary to be selective. So, even though a great many subjects have been covered, some in fair detail, I've chosen the topics that affect the majority. Rare, seldom-seen diseases simply have not been included. So, if you seek information on some strange disease, rarely encountered in this country, it probably will not be here. The more voluminous textbooks will have it somewhere. Experience has shown me that more people have the common illnesses rather than the rare ones.

Deciding what to include and what not to include has been assessed in, what I feel, is a sensible and practical method. For many years I have been actively connected with the media, chiefly the press, television and radio. I have been writing for all three, doing a twice-a-week national television segment for nearly a decade, plus a daily radio network piece. The writing goes back to university days. This, with well over thirty years in family practice, has given me a good insight into the problems of mankind.

The media work brings an enormous mail, and I have always been intrigued with the diversity of questions asked and problems posed. However, over all these years it has been astounding to see the regularity with which similar problems have come to light.

Basically, these come down to about 100 chief topics that trouble people. They are asked in all manner of different ways, but in essence they are identical.

So, armed with this, along with the information gleaned from questioning patients in my own medical rooms for more than a quarter of a century, the basic design of this volume has taken shape.

I hope you will use the book often, and whenever you feel like it. Use it as a guide if and when you become ill.

It is not meant to replace the diagnostic skill and sensible advice and treatment ordered by your own physician. He must remain the link between you and sound medical treatment. Rather, this book will be used in a complementary manner. It will augment the value you will gain from your doctor, probably give you greater insight to your problem, or do the things he has not time to do.

In addition, it will provide background information. It will set out ways in which you can gain better health by sensible living and sensible thinking.

If it does a fraction of all this, I will feel amply rewarded for the enormous amount of time and effort, extending over the past two years (in my spare time and holidays), it has taken to put together.

In conclusion, might I suggest that everybody should set a goal in life in regard to good health. Set yourself a target to keep fit and well, in mind and body, and this will give you something to work for. This book also tells you how to achieve this.

Never forget that good health basically comes from God. I am a Christian doctor, and I believe the principles expounded by Christ. Apply these laws to your everyday living, and you will have the mental and psychological basis on which to build better health, each day.

My good wishes are extended to you, and I trust you will maintain good health for many years to come.

John F. Knight.

Sydney, Australia.

Downloaded from Fountain of Knowledge Library

SECTION 1:

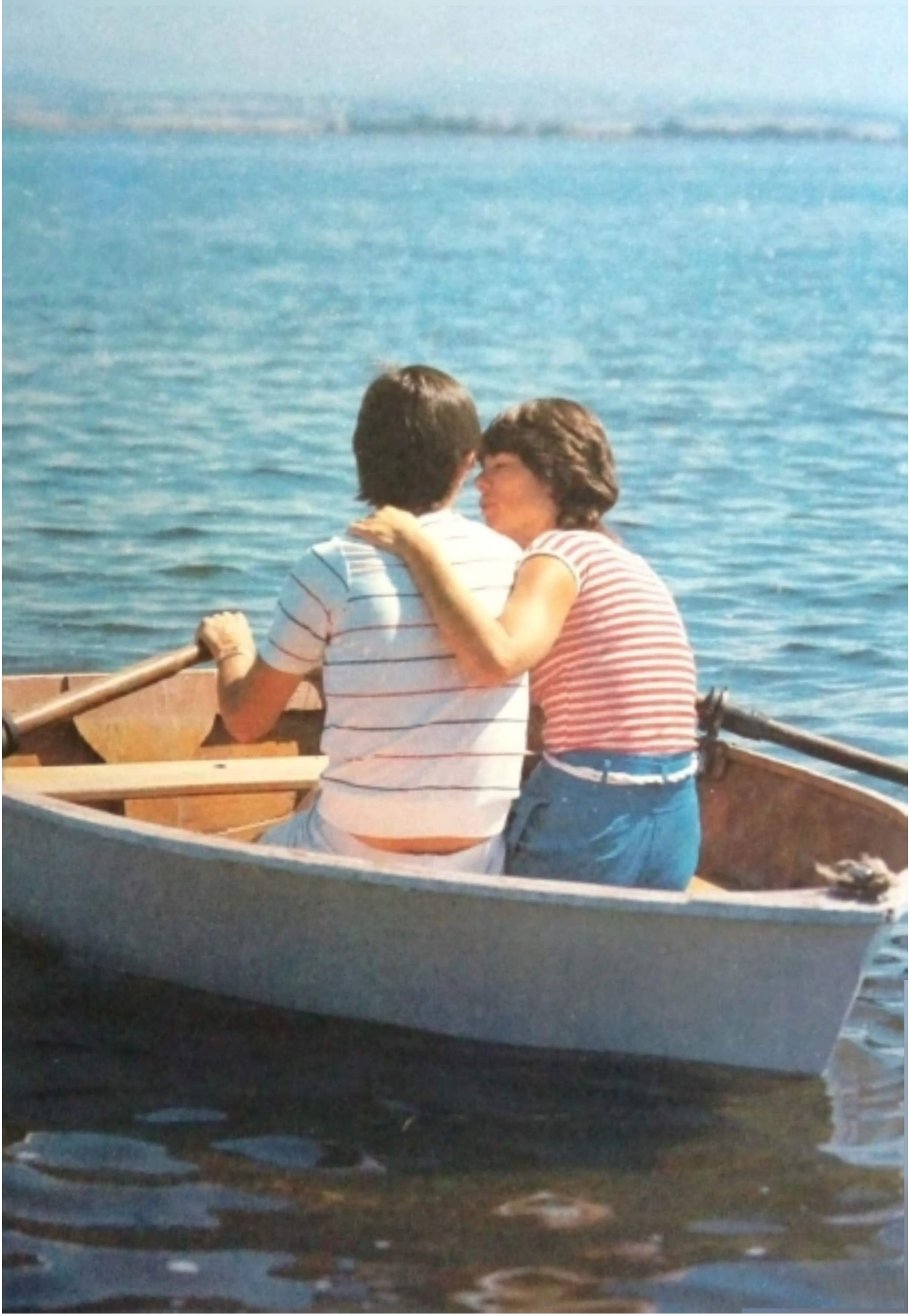
all about marriage

Just married! Sounds fine. But how well do you know your marital partner? Superficially, you are aware of the nice side. But as the weeks, months and years pass, the "other side" inevitably shows through, sometimes sooner than anticipated. But a sensible, understanding attitude can assure both partners of success, right from the start. The principles last for ever.

CHAPTER HEADINGS:

1. Just Married! "Getting To Know You" 13
2. Setting Up a New Home 18
3. Baby Days and Boys and Girls 25
4. Marriage and Finance 30
5. The Social Aspects of Marriage 36
6. All About the Sex Game 43
7. All About Family Planning 50
8. The Key Reasons Why Marriages Fail 59

Downloaded from Fountain of Knowledge Library



Downloaded from Fountain of Knowledge Library

Chapter One:

Just Married! "Getting To Know You"

So you are now married!

Congratulations!

This is one of the most satisfying periods in a person's life. It is a major milestone, for it represents the start of a totally new way of living. Gone are the days when you were part of the family circle created by your own parents. Right now you are out in the big world about to begin the circle all over again.

Just as your parents established their home several years ago, and subsequently made you part of it, so you are embarking on a similar course.

You are about to set up your own family circle. In due course, it is to be hoped, the two of you will produce and establish a family. You are hoping this will be a happy, healthy family that will bring an enormous amount of pleasure to many people, first to yourselves, and secondly to those who will ultimately form your very own family—your children.

From the start, let's point out how important children are to fulfilling happiness and contentment within marriage.

Despite what modern society might say, reproducing and bringing children into the world, and subsequently raising them is one of the greatest delights available. Fashions and fads come and they go. But this one stays for ever. The Pill may have altered the concept of family planning, but the basic idea of procreation continues.

Some couples foolishly believe that they will go through life caring and thinking of themselves only. They have no wish to live for anyone else but themselves. This of course is a selfish as well as a foolish concept.

I can assure you, that concept will not last. Humans are built to love, make love, and reproduce. It is one of the most forceful inbuilt intuitions we possess. Although during the first few weeks and months of your new-found euphoric world you might think that your passions will never fade, that you are meant for each other, that you do not want anything or anyone else to become part of it, this will gradually alter. It may take months, or even years. But sooner or later, the desire to reproduce will come strongly upon you both.

Over the years, I have seen this picture unfold on countless occasions. Efforts are often made to "take the Pill" regularly every night, or use some other fool-proof system of birth control. But it doesn't matter how rigidly the system is adhered to, sooner or later a change takes place. One partner or the other decides to opt out. Often it is the girl who begins to think wistfully about a family. Suddenly she realises that life is becoming empty. She sees her friends pushing prams and strollers. She sees tiny feet following her other married friends. The feeling becomes overwhelming. She too has the desire to do the same thing. After all, what is life all about?

So, whatever the preconceived plans and

Downloaded from Fountain of Knowledge Library

ideas, the overwhelming desire takes hold. She is not happy until she becomes pregnant and gives birth to a new life.

Or it may be the husband who "becomes clucky." Suddenly he realises that his peers and current friends are continually talking about what "Little Jimmy" did. How well he is sleeping at night . . . taking his feeds . . . how he looks just like dad . . . mum . . . how he has said "Dad-Dad" for the first time . . . and the husband has witnessed the glow of happiness, satisfaction and pride that has accompanied such talk.

What's the marriage game all about? he suddenly asks himself. Say, why should *we* be left out of this business? Let's get started!

A quick talk often solves the problem. Why bother trying to get the house paid off before deciding to start a family? Why try to pay for the car, the refrigerator, the television set? It looks as though it could take an age. If we don't start until then, we will be geriatrics and probably incapable of having children!

These thoughts tend to race through fertile young minds. If one agrees and the other doesn't, the end-point is often one that is not very important. The wife can easily stop taking the Pill, or cease using whatever contraceptive measures she might be on. In the early stages of marriage, this side is usually left up to the wife.

But for whatever reason, if pregnancy ensues, one thing is absolutely certain. Both partners are invariably agreed that it is a good idea, and usually are delighted. This might take a bit of time to adjust to. In fact, it might take several months.

I have frequently seen one partner, or sometimes both, absolutely furious when told pregnancy has taken place.

"Jim Will Kill Me"

"Jim will kill me," a shocked spouse might say, particularly if it is the first time, and perhaps the marriage hasn't been on the road too long. "We had planned to do so many things before we started a family."

For what reason the woman is prepared to take the brunt of the blame I will never understand. After all, conception must be a two-way deal. Jim, or whoever the husband happens to be, is just as responsible for pregnancy as his wife is. After all, the act which produces pregnancy always requires the co-operation of both partners. So why should the wife take all the blame?

I am always happy to spend a little time discussing this aspect with a recently married pregnant woman. Or with any other pregnant woman, for that matter.

"Don't you go accepting blame," I say, in firm tones that leave no doubt. "Bring Jim (or Harry or Joe) along and let me talk to him. I will put his thinking right!"

After some discussion along these lines, the wife is usually pretty happy about the whole thing. In nearly every case, whether baby was family-planned or whether it "just came," the mother-to-be is invariably delighted.

What is more, the husband is almost always just as happy. It may certainly take a few months, as I've already said. But once the idea sinks in, he suddenly realises he is to become a father. He will become like the rest of the fellows. Now he will be able to discuss what *his* toddler is doing, how *his* baby is making out, instead of having to listen to the ecstatic (but rather dreary) ongoing talk of his proud-father mates. Now he can say how little Billy (or whoever) slept last night . . . took his feeds . . . looks like daddy . . . is a gem and a genius . . . pulled daddy's nose . . . said "Dad-Dad" for the first time.

In all my years of medical practice, and I've been around now for a long time, and seen an enormous number of young married couples in this situation, I cannot remember very many who were stoically against the pregnancy deal when it has finally occurred, whether planned or not. By the time the baby arrives, the parent who was most against the idea in the first place, invariably becomes the one puffing with most pride and elation and adulation when the final moment arrives and baby comes.

On the other hand, of course, many couples definitely plan to have their first baby early in the piece. Some prefer to delay for a year or two until they "become established." However, the point I am making is that reproduction forms an integral part of the home circle. In fact, without children, there is no such thing as a home, let alone a home circle. A circle means something complete. Two people do not make a complete circle.

Babies, infants, children, and later adults (for all children finally grow to adulthood), are an integral and important part of living. I hope that you take them into your planning. In this way, you are guaranteed with much more assurance, of a happy, successful, on-going marriage.

However, producing and raising a family is but one side of the marriage deal. It is very

Downloaded from Fountain of Knowledge Library

important, but in the first instance, two people must learn to live together.

This might sound a simple statement. But it is extremely important. Of course a couple can live together, but apart from just living, they should ideally live happily. There is absolutely no point in existing in the same house. Happiness is an essential and key factor in life. Without it, life often becomes a meaningless jumble of days, weeks and months which merge into dull, lustreless years. But when happiness, joy, excitement, and compatibility are also injected into the relationship, this gives so much more meaning to the entire undertaking.

Ideally, marriage should encompass all of this. Of course in the first weeks, months and probably years of marriage, the fact that it is such a big new venture often helps it skip along merrily. There are new-found joys of getting to know one another—really well, not just superficially as often occurs in premarital relationships when both are likely to put the best foot forward. Each comes to know the other on a very intimate level. Each discovers the likes and dislikes of the other. Everybody has his or her little peculiarities, quirks and foibles. If we did not, we wouldn't be human. It is part of the happening part of living.

Personal Habits

Often people have eccentricities or habits or ways that tend to irritate another person. During early marriage, it is time to take stock of all these things, both in yourself as well as in your spouse. The well-adjusted person will learn to accept such factors in his/her partner without grumbling and without making a big thing of it.

"Jim is always late . . . Jim is untidy . . . Jim never helps me . . . Jim never lets me drive the car (just because I smashed my own up twice before we got married) . . . Jim is selfish, he always likes his own way, and gets grumpy if he doesn't get it."

I've heard the complaints year in and year out, and no doubt you have heard yourself muttering these over to yourself, your mother and your girl friends, time and again.

What about Jim? Have you ever stopped to think what he might be thinking? "Jane nearly killed herself with those car smashes, and she is still paying off the bills. Stupid girl, not getting her car insured! I'm certain she won't wreck this one till we've paid off the last lot of bills anyhow. . . ." "Why does that woman keep screeching at me every time I'm a bit late? After all, she's got nothing to do all day long except do a bit of housework, and get ready and be early, which she invariably is, and then complains if I'm late, after I've slaved my inside out at the office working and trying to get to our appointment on time. She never lets up. . . ." "Why can't she get the washing-up done before I get home for tea at night? She can't expect me to help with the washing on the week-end, I'm too involved with earning a living. . . ." "Why can't Jane see that we must save money if we ever hope to pay for the house and everything in it that she wants? She says I'm selfish when I try to get her to cut down on the spending on ridiculous things that are not necessary. Says I'm mean and stingy. That's a great way to help a guy get on and get debts out of the way." So it goes on and on.

This may not be any particular couple. Rather, it is a sample of the type of talk that goes on with many, many couples. In principle, it is the basics that matter.

"Getting to Know You" was a lovely song of a few years ago, and I've never forgotten the punch line, and the first few bars of the song. It has stuck in my mind, and I often recall it when I hear young marrieds (and older ones too, for that matter) grumbling and griping and sniping at each other.

"Get to know each other," I say, either out loud or to myself. "Get to know each other well. Learn each other's faults, for sure. But go the extra step. Get to know each other's good points too. For just as surely as there are bad points, there are an equal or greater number of good ones."

For instance, if Jane bothers to think closely about what her young husband is trying to do, she might see the picture in an entirely new light. If he happens to be late for appointments, or late home for dinner at night, then there is probably a good reason for it. He obviously puts work high in his priorities, at least during the week. He is keen, ambitious, and definitely headed for bigger and better things.

Inevitably this will lead to a bigger, fatter pay-cheque in the long run. This will surely yield a beneficial spin-off to her. The house will be theirs earlier than had been hoped for. Probably the car will be paid for too, or he may even be supplied with a company car if he keeps notching his way up the ladder. The essentials that make life interesting, home comforts greater in number and better, the future more secure and solid, are all involved. This is where he is headed, and she is part of the parcel. It is largely

Downloaded from Fountain of Knowledge Library

in *her* interests that he is working so hard at his trade or profession.

Jim is untidy. So what? There are worse evils than a husband who probably doesn't fold up his pyjamas each morning, and leaves a few things around the house. Jim never helps her. She spends her total time at home "housekeeping," except for a part-time job a couple of mornings each week. In that case, there is ample time to do what she is supposed to, such as keeping the house clean and tidy, making sure meals are well prepared and ready on time when Jim comes home, and making certain that everything in her field is done to the best of her ability. This includes the washing and the ironing and all the other household chores. So there is really no need why she should expect Jim to be there, willing and waiting to do her work, just as she would not be expected to spend her spare time doing Jim's work.

As far as the car goes, well, perhaps there is room for some sort of mutual reappraisal there. Today most women drive the family car. No doubt, when the last bill is paid off, probably a few more driving lessons will enable a mutually satisfactory answer to be found in this area.

You may think that this example of Jim and Jane is a little overplayed, but it is meant to point out general principles. The fact is, however, that the couple I've discussed carried on in exactly the way I've quoted, so it is not a figment of my imagination.

We're All Individuals

The principles are that every person is an individual. Every individual has his or her way of living, working, playing, and generally existing. This is derived from the culmination of many interacting psycho-social situations. It is the current end-point of what has gone on in life beforehand. This is basically called "experience."

During life, a great variety of sensations are experienced. Many of these are inscribed on the subconscious part of our mind, and there they stay, often for ever.

Our reactions during life are invariably tempered by the contents of our subconscious mind, which is often aptly referred to as the computer of the body.

What goes in will inevitably affect what comes out. Often there is little or no control of what pours into our subconscious, for this is occurring every waking moment of every day. Our reactions are often spontaneous, immediate, and taken without too much thought.

Fortunately, however, we have a control mechanism over what is inclined to bubble out spontaneously. This is the so-called control of the conscious mind. Therefore, we all have some control over how we act, how we behave, how we react to situations occurring at all times.

This is very important in the marriage situation. It is important right from the start. In fact, if we learn to control our reactions, control the way we speak, our attitudes and actions, then we are headed for a happy, successful future. This includes life in general, and in its broader sense is not restricted to marital success, although it is vital in this respect too, of course.

"Do Unto Others. . . ."

Get to know each other as soon as you can. Learn to give and take, to share and understand. For many years I've firmly believed that the simple golden rule, which Christ expounded many years ago when He delivered his message now widely referred to as "The Sermon on the Mount," is the best rule by which to live. In short, this merely says: "Do to the other person what you would like him to do to you." Put it any way you like, but this fundamental law should

Downloaded from Fountain of Knowledge Library

regulate and rule our lives, not just here and there, or intermittently, or on special occasions, such as when friends and neighbours are around, but all the time. It can readily be incorporated into everyday living. It can become a way of life.

It is basically not hard to adhere to. If you forget everything else, and simply remember to try to practise this simple little rule, and let it be your guiding star throughout life, I believe that it will have been worth writing this book.

Why not write it out on a card and place it in a prominent place in the most frequently used room of the house? Such as on the wall or window in the kitchen in front of the sink. Or stuck to the refrigerator. (You could probably get a sign which reads "Happiness" . . . "Keep Cool" . . . "Slow Down." Have you ever seen them? They are great. They will add to the force of your card each time you look out of the window or go to the fridge.)

Say the golden rule over to yourself many many times a day. If you find that things are forever getting off the rails, repeat it again. You might even like to write out several identical cards and have them in key parts of the house. And keep one in your handbag or pocket.

I might add that this goes for both partners. I am not simply talking to the wife, but to the husband too. He would do well to have a little stack of "golden rule" cards with him, and place one in the prominent places where he will inevitably see them many times a day.

If a friend or acquaintance asks why you have a notice like this stuck up in front of your nose, it is an excellent opportunity to tell him your philosophy in life. You need not pound his ears off with a church sermon. Just let him know what your attitude to others and life in general happens to be.

This of course has an immediate twofold effect. Firstly, it spreads your own personal views around, and there is nothing wrong in this. But even more important, it reinforces on your subconscious mind what you believe and are trying to put into everyday practical action. There is nothing like having several senses take messages to your subconscious mind. Reading (using the visual pathways), hearing (similarly using the auditory passageways), and speaking (using the motor pathways of the speech function) all re-emphasise on your subconscious mind what life is all about, and the measures you are taking to try to upgrade it, to make it happy and successful, to make it a better, brighter, more successful one.

I can assure you that the suggestions outlined in this brief introductory chapter are worth trying. They work. They seldom fail. Why not give it some thought? Read the chapter again, discuss it with your partner. Pull it to pieces, and then throw all the bits into the melting-pot, and finally make your own pattern of living. Use it as a general guide. I am sure that you will gain a major benefit.

Downloaded from Fountain of Knowledge Library

Chapter Two:

Setting up a New Home

Establishing a new home can be an exciting experience. But there are many initial difficulties to be overcome. Settling down and working out delineation of duties is an important starting-point. Then making decisions on work, finances, housing, children, and many of the other inevitables, requires thought-provoking sessions. However, with time and care and common sense, most problems have an answer.

Marriage. The wedding is over. The honeymoon has come and gone. Finally, after the initial ecstatic days of happiness, or sharing each other's company in an intimate and pleasing manner, the hard, cold facts of life have to be faced again.

All good things come to an end. Like holidays, and having good times, and . . . having a honeymoon. However, it is usually a "once only" business for the average couple.

It comes to an end, and it is back to the routine again. In this hard, cold world, we have to eat, live and keep alive. There is no short-cut method. This all adds up to having to work to keep the wolf from the door.

But first of all, it means having a door in case the wolf calls. Having a house, establishing a home, are the first essentials of the marriage game. You can enjoy love, but you can't live on it. Neither can you sleep in the park and live on bread and water. In these off-beat days, some couples try to, and some even seem to get satisfaction out of "roughing it." But if you are like the partners of the other 110,000 marriages that occur annually in Australia, you will want a nice place in which to begin married life.

So, the childhood game of playing houses takes on new meaning. Suddenly a new concept enters your thinking. This is the real thing. At long last, you are about to establish your very own home.

Today, the mechanics of finding a home and doing just this are complex. Soaring inflation, probably the worst in history, is with us still, and does not seem too keen on leaving. All this means that renting, buying, leasing accommodation is a marathon financial undertaking.

It often means that sheer necessity forces both members to seek work to pay the bills. The biggest single factor is either paying the weekly rent, or paying the loan and interest off in the event of a house being purchased.

In the early stages this is not a bad thing, for if both partners are fully occupied, it fills the day, and each is given more or less equal responsibility in the setting-up-home deal.

Downloaded from Fountain of Knowledge Library

Today, there is a greater move toward sexual equality. In fact, it has arrived, and legislation over the past few years means it has come to stay, even at the official level.

So, while boys and girls go out to play, married couples go out to work. And work hard, too. Often the harder one works, the greater is the financial reward. But we will come to the fiscal side of the marriage situation a little later on in this section. It is a very important one, and one that requires the careful consideration of both partners.

From an early start in married life, many couples find it a good idea to sit down and work out what their respective ideas are. They will carefully calculate what is to be expected of each over the next period of time. This may be called, if you care for a particular identification phrase: "Delineation of Duties."

In many cases, this will probably come automatically, and not need to be discussed. However, the well-organised couple, and these are often the people who get the most out of life, both during their single days as well as after marriage, often like to have a clear set of rules by which to live. Maybe this can be carried out in the many premarital discussions that will have occurred.

Maybe it will be some time after marriage that the necessity for it takes place. Others will find that as soon as they start working again, it is necessary to work out a broad plan for their future. In this respect, it must become clear that each partner will carry out certain obligations.

Very early, decisions must be made on how finances are to be handled. How will the pay packets be divided up? How much will be banked, or allowed for "housekeeping"? Is one lot banked, and the other used for day-to-day running of the home? Or does each account for his/her own funds, and put forward a certain proportion for general living?

This all becomes part of the overall pattern of what the couple have in mind. But one thing is for sure: if you hope to get ahead in this world, and keep your head above water, then a plan must be worked out very early, and adhered to right from the start.

Sharing the Duties

If both partners plan to work, then there must be a general sharing of domestic duties. In short, if there are two breadwinners in the unit, there must also be two housemaids. We covered this briefly in principle in the previous chapter, but there we assumed the wife was not working. When both are energetically spending eight hours a day at work (plus perhaps another one to two hours travelling to and from work), this minimises the balance of available time. Sleeping, eating, preparing food and doing the other essential duties, takes so many hours. Which leaves only a relatively small amount of time to do everything else.

To avoid arguments which may inevitably crop up later on (after the initial euphoria has waned a little), it is really worth discussing these matters "in depth." Why not sit down and write down all the possible items of work (in general principle) that will regularly occur? There is nothing like setting things down on paper for clarity. Add to it, and subtract from it. Then discuss the way in which these activities can be divided up. "I'll do this; how about you taking care of that?" "Would you like to be responsible for this activity, while I get this section done?"

It might sound a bit airy-fairy, but in practice, it works. This way you will not be accusing one another of shirking. You will each bear relatively equal loads.

In many cases the girl is good at finances. Many women are really keen and mentally alert when it comes to running the money side of the house. They are good buyers, can dig out the bargains and make sensible purchases, and in short, are simply way ahead of males. Not always, of course, but often.

Therefore, many males find it a good idea to leave the financial running of the home to the wife. It can be worked out how the funds are to be divided up, and then the actual *modus operandi* can be left in her hands.

Conversely, the husband might be excellent at other aspects. In some homes he actually likes doing the cooking, or the domestic chores. Some wives like cutting the lawns. Some males are happier tinkering in their spare time with household repairs, getting the hundred-and-one little odd-jobs (which abound in every home) carried out quickly and expertly. Or the place may need a paint, or the squeaky door needs fixing, or some electrical faults have to be attended to, or the pipes become blocked and the sink won't empty properly. So he prefers to accept the responsibility of these aspects of home care.

What about the shopping, both for clothing as well as food, as well as things in general? Once more, it depends on the mutual likes and dislikes and capabilities of the two. Some men hate shopping. I do. In fact, my wife has kindly done the shopping for me and my family for all our

Downloaded from Fountain of Knowledge Library

There is nothing quite so rewarding as sharing a few hours in a mutually planned garden.

married life. I hate buying shirts and socks and other items of clothing. She has good taste, knows what I like, and that is that. Likewise, she does the domestic shopping, the food, and what-not.

On the other hand, many males love pushing a trolley around the supermarkets, doing the weekly buying. It all depends on how you feel about these things, and what your individual tastes are like. But, as these activities are going to continue on a never-ending basis for the rest of time, it is worth coming to some sort of mutually satisfactory pattern of living early in the piece.

Of course this does not mean you have to stick slavishly to the plan. If I decide I want to buy a tie, I go out and buy a tie. (Last time was about fifteen years ago.) This upsets nobody. But it is general principles of an on-going pattern that are worth deciding upon, the general overall scheme, that we are discussing.

Delineation of activities is a good idea. It sets out a general blueprint for future living. It can be varied, altered and changed about at any time according to its practicability and the wishes of both partners.

Of course, from time to time, this pattern will have to be altered, probably radically. It may be a satisfactory method right now, but when baby number one arrives, it may have to be totally changed.

By working out your respective duties, in general principle, this will also solve once and for all who is "boss." Now every working unit must have a head. That is undoubted. But in the marital game, things are different today from what they were a few years ago.

In some instances, because of the personality types involved, one person may appear to be the dominant partner. The other one may automatically tend to be more submissive. There is

Downloaded from Fountain of Knowledge Library

nothing wrong with either, for a submissive outward character is not necessarily a weakling. Neither is an aggressive, apparent born leader necessarily just that either. Often the bombastic, vocal person is all talk and easily deflated, and deep down this is his/her subconscious way of trying to boost his/her own ego, and get noticed in the world. In a sense it may be his/her "ego-tripping method."

Frequently it is best if there is no boss, in the true sense of the word. Rather, a workable partnership is far more happy and peaceful. Often these are the family units that tend to stay together and last longer than the other type.

Actually there is no hard-and-fast rule about all this. Some units may find it more satisfactory if one tends to make the decisions, and act as the leader of the team. One may prefer this. Conversely, if both have an equal say, and if each respects the opinions of the other, this is often the most rewarding and, in the long run, the most satisfactory arrangement.

A marriage deal is a fifty-fifty arrangement. The role of the wife can be extremely important, even before there are any children involved. Through her ability, attitudes, opinions, she can wield an enormous influence. Often women who are quietly spoken are very forceful in their own way. The words they speak, and the attitudes they reveal can have an enormous on-going effect on the total home picture. A husband should never underestimate the power of a woman. He who does is a fool!

At the same time, the influence of the husband can be major. Expressing his feelings, attitudes and opinions can also have a major influence on the home, both before as well as after children arrive. Wives are well advised to listen to what their husbands have to say, and take note, for often (believe it or not), what they say makes sense. Not always, certainly, but often. Frequently their ideas can be tempered with added ideas from the wife, and the final composite picture can be a rewarding one for the family unit.

Any partner who thinks he or she is always right is also heading for trouble. In this world, nobody is right all the time. In fact, experience has shown (as we can all remember if we look back on life), that in a great number of cases, probably the majority, ideas and thoughts we expressed at one time, feeling we were 100 per cent right, later turned out to be extremely foolish and unsuccessful notions.

Discuss Your Problems

Discussing problems, working out plans together as a unit, is often a wise idea. There is nobody alive who has all the answers to all the problems that will occur. This applies to any facet of living, but it also applies to marriage, not only early in the piece, but right throughout it.

Pool your ideas, pool your hopes, ideals and dreams. In this way, with sensible discussion (preferably in an unheated way), much good may accrue.

Two heads are better than one. Whoever said that first was a genius. It was probably somebody's marriage partner!

This is very true in marriage. How often in business will an executive call in a fellow director, or another person from down the line, for an opinion, or expression, or merely to consider an idea or thought! The business world has known the value of multiple minds in gaining a successful, workable line of action. If it is good enough for successful businesses, it is just as appropriate for the business of running a home unit.

Family discussions are best carried out when everyone is cool, calm and collected. So often what should be simple, sensible talks, end up in heated rows that finally give two people headaches, often with one finishing up in tears and the other shouting and waving his arms. This is far from funny. More seriously, it is far from rewarding. Time, effort, energy, and calories have been needlessly wasted.

Keep calm, cool, mentally occupied with the problem if you hope to gain some value from discussions. Go into problems with an open mind. Don't put up an idea with the hard-headed approach that "I'm right, you're wrong." That will only breed disaster from the start, and cannot possibly yield a beneficial outcome. Be prepared to listen to the points of view put forward by the other partner. This may all sound a little as though I am preaching, which is not intended. These are merely simple suggestions that, as most people know, work. It is often worth while writing things down, for this makes them clearer. That is exactly the intention of these chapters. They are not meant to be a dogmatic exposition of my thoughts on marriage. They are simply suggestions, guidelines, thoughts that might make your early days of married life a little smoother.

There are many psychological aspects of marriage that are very important. In these days of medical enlightenment, many know what these

Downloaded from Fountain of Knowledge Library

include. However, despite the fact that we are living in the last part of the twentieth century, many are still abysmally ignorant of some of the simple facts of life. This is not casting any aspersions on anyone's knowledge, but is simply a situation that I have noticed in my close association with many people over many years.

So, a few words along a slightly different tack.

Boys coming from families where they were the sole member, or those coming from an all-boy family, are often not as well versed with the failings and foibles of the gentle sex as those who have been brought up in a mixed family, or who attended a co-educational school. Also, many tend to forget basics that they should know quite well.

Women's Problems

It is worth briefly mentioning some of the obvious things right now. Women tend to have their ups and downs which are related closely with the menstrual cycle. This is a well-known fact.

Husbands, particularly in newly established family units, should consider this fact of life. If your loving wife seems a little nervy, irritable or downright cranky at certain times of the month, don't be too ready to condemn and criticise. If she doesn't jump to life with unbounded enthusiasm at some new idea, or scheme you promote, or show excitement at the announcement of promotion you've achieved the instant you talk about it, do not fret and fume and think she is unappreciative or insensitive.

The hormonal changes that regularly occur during the twenty-five to thirty-day cycle in women can produce enormous psychological changes. That is why many women go through times of abject misery and deep depression. This is most likely in the week preceding the onset of menstruation, when profound hormonal changes occur. During this time the female ovary produces excessive amounts of a chemical called *progesterone*, which is aimed at making the uterus ready for pregnancy. But apart from this, it has other unrelated effects. A common one is to produce fluid retention. In turn, this can often give rise to marked emotional variations in mood, attitudes and demeanour.

This sometimes means that the little lady will no longer be the ever-loving companion of last week. Instead (at worst) a cranky, bad-tempered, irritable, picking "fishwife" may appear. Everything you do is wrong. You can't put your foot right. You are miserable, unkind, thoughtless, rude, and so on and so on.

I can assure you that this is usually short-lived. When it occurs in a normally happy, contented woman, as soon as the menstrual flow starts, and the hormone level reduces, she is back to her amiable self once again. It all sounds a bit strange, I know, but once more, this is a fact of life, and it is well worth knowing that it might happen. Great numbers of women are affected in this manner. Some are only mildly involved. In others, it is far more severe. They all vary in extent and degree.

Try not to get too downhearted, for tomorrow is another day. When "that terrible time of the month" is over, they are invariably as nice and friendly and kind and lovable as ever. Often they are better than ever. Frequently they are unaware of the way they have been behaving. Some are, and regret it immensely. Others simply forget, until the next round occurs.

Fortunately, these days, it is not necessary for women so afflicted to have to put up with this indefinitely. Many simple lines of therapy are available which can vitally and beneficially affect such women.

In fact, so important is this part of married life considered to be that a special chapter has been devoted totally to it, its recognition and treatment. For this you are referred to Section 8, the part entitled "Strictly Feminine." Here you will be able to discover just what to do if this is

Downloaded from Fountain of Knowledge Library

your personal problem. We suggest husbands also read this chapter, for they will find out a lot more about the problem, and particularly, how to cope with it. After all, this is the most important thing.

Establishing a new home involves the close co-operation of two people, co-operation in its complete meaning. It covers the side of marriage wherein the financial aspects must be taken care of. It affects the physical, intimate side of marriage, which includes sex, making love, intercourse, and the areas of marriage that may be referred to as the psycho-social side.

Sex forms a very important part of married life. Indeed, were it not for this, one wonders if marriages would occur. But seeing it is with us, and looks like being here for a long, long time, it may be accepted as being an integral, often overwhelming part of the marital situation.

More will be said about this later on. But it is mentioned here for completeness. Just as the couple may learn to give and take in respect to the setting up of their home, delineating their duties, adjusting to each other's temperaments and mood changes, so giving and taking and sharing is vital to success in the sex part of marriage also.

Be Gentle

Some people try to enshroud sex with all sorts of mystique. Some try to make it look ugly, dirty, and associate it with greed, lust, promiscuity, disease, and so on. Perhaps these ideas are right under certain circumstances. But within the marriage bond, sex should be regarded as part of life, something physically available that can be enjoyed to the full extent.

With youth on your side, when your hormonal system is working to full capacity, as it certainly is in most couples of average marriageable age, this is the best time to make the most of what you have available.

But as everything else should be shared in a kindly manner, this applies to sex also. It is not there merely for the grabbing. Self-gratification by one partner to the complete disregard for the other will only bring ultimate unhappiness. Each should think of the other, their needs, their likes and dislikes, their mental and physical attitudes. It may take some time to work all this out, for the sexual prowess and capabilities of each will vary. It is an aspect that must be worked at, like all other aspects of married life.

It takes time, gentleness, persuasion. However, if each considers the needs and wants of the other, very soon an admirable sexual adjustment can be worked out.

The male who wants to indulge in intercourse every night, have his orgasm and roll over and be asleep in five minutes flat while his ever-loving wife is still somewhere up in the clouds waiting to achieve a climax of her own is thoughtless in the extreme. This situation is not likely to last indefinitely. One day she might just opt out and say, "I've had enough, young fellow. Life was meant for me to enjoy a bit of the cake too." And he comes home from work one day and she is gone!

Don't snigger and say, "What's he talking about? Rubbish and nonsense."

The hard, cold fact is that practically nearly every smashed-up marriage in this country (and every country for that matter) has sexual incompatibility as the basic cause. It goes by all sorts of strange names: "Mental cruelty," "thoughtlessness," "he beat me up," "he was unkind," "there were money problems."

But look behind the scenes. Clear away the euphemisms, and usually (say about 90 per cent of the time, plus a little) sexual incompatibility, or downright pigheadedness, foolishness and selfishness at the sexual level are the basic causes.

It is food for thought. This will be dealt with in greater detail later on. It is mentioned at this point for its importance. Sexual compatibility is essential for a happy, long-lasting marriage. Sharing, consideration and being thoughtful and considerate of your partner are the basics of success in this field.

Downloaded from Fountain of Knowledge Library

Downloaded from Fountain of Knowledge Library

Chapter Three:

Baby Days and Boys and Girls

Baby number one eventually arrives. Often others follow. They grow up, and start to develop expressions of their own. There are many simple measures that can help parents cope with the transition from a "no child" family to a family with several children. With a little thought, happiness can be increased within the circle of family life.

The first major change during marriage occurs when the wife becomes pregnant. This may be premeditated and "planned." Or it may occur "just out of the blue." The latter was the usual way in the pre-Pill era when effective methods of family planning (the euphonious term for birth control) were not available. The methods used up until the late 1950s were crude, clumsy and often ineffective.

But today, with modern contraceptive facilities readily available at modest cost, many couples deliberately plan when their babies will come, and how many. There are good and bad points about the system, but let's accept the fact that it is a way of modern life in the Western world.

Sometimes, in spite of careful planning, the baby gets on the assembly line earlier than expected. Sometimes through illness (vomiting, diarrhoea, other medication) the Pill becomes ineffective, and pregnancy ensues.

In any case, whether planned or not, let's assume that pregnancy has taken place. If it comes within the general planning of the couple, this is often most satisfactory. If it comes a year or two "before schedule," this often upsets the couple who are trying, often, to get financial security. But nonetheless, baby is usually welcome when he/she puts in an appearance, and in any event it starts to make life more meaningful.

Wives who elect to work can often continue with their normal routines during the early months of pregnancy with little inconvenience. In fact, some can work up until the last couple of months. I feel that common sense should prevail. Be guided by the way you feel, and follow your obstetrician's advice. There is little point in working up until the last minute merely because it will yield a few extra dollars when it may jeopardise your health or baby's health and general welfare. It simply is not worth it. Often pregnancy produces severe fatigue, and additional rest is frequently welcomed. This may be quite impossible when trying to run a home as well as a job.

Thoughtful husbands will realise that the baby—either coming, or actually born—is a two-way deal, and will come to the help of their wives. Often lending a hand with the household chores and the general running of the home at this time is more necessary than ever,

Downloaded from Fountain of Knowledge Library

particularly when both partners are working.

If there are other children already in the family circle, it is a good idea to tell them as early as possible that a new arrival is soon due. This offers an excellent time to instruct older children in the "facts of life." Indeed, it is the best possible situation.

Take them into your confidence and tell them as much as you feel they may understand. Buy the books, "*Everything a Teenage Girl Should Know*" and "*Everything a Teenage Boy Should Know*" (printed by the publishers of this book and available from their offices in Victoria). These have many illustrations and pictures that can be shown to growing children, even though they may be well under the adolescent years. If they can see in pictures what is happening to mummy's inside, then actually see and feel from the outside, it will reinforce the message. Their little subconscious minds often absorb an amazing amount of detail which stays there for ever. This can make your task of telling them all the things they should know later on, so much easier. Also, if the older ones get the message, they will often, in turn, educate the younger members of the family.

With babies, the biggest problem as far as the second and third (or fourth or fifth if you are brave enough) is with baby number one. Often the first one rightfully assumes a pre-eminent position. Suddenly he/she is relegated to second place. It can take quite a bit of readjusting. So, play it cool. Prepare number one well in advance for what is in store. Making a big thing out of the fact that number two is to be "his baby," "his playmate," "his responsibility" and so on, can put him in a position of enthusiastic anticipation, rather than in a position of uncertainty and competition. Let him feel mummy's abdomen, and let him feel baby moving around (which always happens in the latter months). It is a wise move and will make life easier and happier for everyone when the arrival of number two occurs.

The wife should stick to the advice offered by the doctor. Much information on pregnancy is offered in the next section of this book (see Section 2). It is worth spending time reading this when the time comes, or even well beforehand so you will know what to expect.

The husband should do his best to co-operate so as to make life as smooth as possible for his wife and other children, if they are already present.

The arrival of a baby is always an exciting time. It really marks the start of a new era. The family circle is starting to take shape, materially and practically. There is nothing like a new life to add zest to living! It will also add a few sleepless nights and furrowed brows, but that is all part of the business of raising a family.

In my opinion, spoiling baby number one is almost as inevitable as morning following night. Parents often allow their enthusiasm to override their common sense with their new baby. It frequently becomes a time-consuming, all-engrossing affair, mentally, physically and emotionally. There is nothing quite like the pride of parenthood, particularly with the novelty of the first baby.

Baby's Inbuilt Computer

However, after the initial euphoria has worn off a little, it soon gets down to a fairly regular routine. And routine there must be. Wives and husbands would do well to consider this, and if it has not already been done, work out a sensible, workable timetable. Maybe there will be a reassessment of the "delineation of duties" that we discussed earlier. Often the husband will have to give added time and attention to duties that once belonged to his wife. Caring for a baby can take time and effort. Breast-feeding (still the best idea, safest and most economical) takes time and effort too. Often wives become very tired, particularly with night feeds and the interruptions that inevitably occur during the first year.

Many mothers get out of bed an inordinate number of times at night, just to make sure baby is "still breathing." Fortunately, most are.

However, it is a mistake to overdo the attention factor. Babies have their own little built-in computers too. Very quickly they learn that being nursed is great. Having fuss and attention is also very reassuring. Yelling babies invariably find that soothing, cooing, maternal care will result, so they rapidly learn how to gain attention.

Parents should quickly learn how to control the situation, and not to let the baby start to rule the home. I've seen this happen so often I've long since stopped thinking it funny or desirable. It is pathetic. A great many women (often first-time mothers) wear themselves to a frazzle by letting the baby take over and rule their lives. In this way, they lose precious sleep, and simply dance attention on their offspring.

It is best for parents to have certain fairly well-planned ideas on baby care. For example, how often have we seen a mother trying to settle the baby down at night, only to see dad walk in (full of exuberance, having told the office all

Downloaded from Fountain of Knowledge Library

about junior's latest advances) wake up the child and play with him, overexcite him, and then listen to him yell and carry on for the next several hours because of his overexcited state? When it comes to settling him down when *he* (dad) thinks it is time to opt out, the baby wants to keep up with the fun and games. So, a vicious circle is easily established.

Peaceful Sleep

It is far better to let baby sleep peacefully on, and enjoy him when he does wake up. Common sense is essential, for parents can make a rod for their own backs which will endure for a long, long time. Let this be a salutary warning! You are listening to the voice of experience. I've watched countless hundreds (probably thousands) of marital situations, and I have developed rather firm ideas on child care over the past few decades.

As the baby develops into an infant, and then into a child, let the authority of the parent come through. Certainly give lots of T.L.C. (tender loving care, in case you didn't know), but be firm. If you give instructions, make certain they are sensible and practical. Then make sure they are carried out by your offspring.

Obedience is vital. However, it is futile to smack your infant every time he does something "naughty." It takes time for him to learn what is right and wrong. I often shudder as I watch unthinking mothers yelling instructions (usually meaningless) at their children, and then slapping them firmly (to the point of tears) when they do not obey. Often the instructions are ridiculous to start with, the child is probably totally unaware of what the instruction means, and is even more overwhelmed with dismay and despair when punished for reasons unknown.

Give instructions in terms understandable to the child. Remonstrate if you are certain he disobeys you wilfully. Punish rarely, and only when it is definitely indicated. Punish on the spot, not two hours later when the relationship to the disobedience is totally lost. Do not wait till dad comes home and load the responsibility onto him.

By doing this, the relationship is also lost. I've seen parents do this, with the task of punishment delegated to the father. In some cases this will cause a permanent rift between the child and parent, the child believing that his father is really being cruel and unjust.

Never forget that the child's subconscious mind is working like a sponge. His inbuilt computer is absorbing and storing everything going on. If unjust things are occurring, these will be recorded in his memory banks, and adverse feelings against a parent may linger on for ever. Occurrences in early life may have their repercussions in later life, most likely in adolescence, when the child really resents one or both parents, and will wilfully go out of his way to make life hard for them. Or probably he will simply pack up and leave home. Never underrate the long-term consequences of things that you do when your children are young.

Of course, it is only stupidity to punish your child as a release for your own anger. How often have you seen a mother beating a child merely because she was in a bad mood, or because somebody had upset her? The child, being the nearest object over which she had some control, bears the brunt of her anger. Make sure you do not fall into this trap, for there may be adverse long-term disadvantages which could bring heartache to you as time goes by.

I believe that children can bring an enormous amount of joy and fun. For sure, they also bring a lot of hard work. They cost money to clothe and feed and educate. But this is far outweighed by the sheer delights their presence can generate. To my mind there is nothing more rewarding than seeing the face of a happy child, recounting some incident, some success or some undertaking. Fortunately these episodes are repeated over and over. A parent attuned to receiving such moments of happiness will have memories to treasure which will never fade.

Never forget that children are worth listening to. Today, many parents are "too busy," or "haven't time" to sit quietly and spend time with their children. As children become older, they become observant, intelligent and interesting. Often they can bring new meaning to life. I am certain that parents who make the effort to spend a little time each day with their children, will get closer to them than parents who are too involved with their own affairs.

It is during these heart-to-heart private talks that ideals can be implanted into the fertile, developing minds. And I don't just mean little ones. This is an on-going process and can continue for as long as the children are at home.

Rather than preach to the children, friendly, two-way discussions, are more meaningful, more productive, and more beneficial, to the parents as well as the children.

Naturally, every parent will try to inculcate into their children what is right and what is wrong. Moral standards in every walk of life

Downloaded from Fountain of Knowledge Library

may be taught, but in a friendly, co-operative manner, not thrust down his throat like a set of textbook rules. This will never be accepted, and may only breed resentment.

Closeness with your children can mean that the communication gap will never open up, and thus a major hurdle is overcome. So many parents and children look on the generation gap—the time-distance between them both—with awe. It exists in many, many families, and prevents meaningful communication. Each believes he is in a different world, and in effect this is true. But if the drift can be prevented in the first place, their worlds can be identical.

Children should learn to respect the property of others, and this is easier when there are several children in the one family. In fact, learning to give and take and share physical property (as well as responsibilities) comes easier and more naturally the more there are in the family circle. Often, of sheer necessity, each must learn to share to make everything go around.

Let your children know that they must work for what they get in life. Many parents sensibly attribute monetary values for things, particularly as the children become older. Money doesn't grow on trees, but many children believe it does, having enormous numbers of items thrust on them during childhood.

Very often, the more a person has, the less he appreciates it. If he has to work for it, to make some physical effort to gain what he wants, pride of ownership means so much more. For this reason, many parents will give the child so much "pocket money" as he gets older, on a regular, weekly basis. But for this he may be expected to do a certain number of listed chores. In this manner he is getting to know the value of money, and this may help inestimably in his future life. He learns values, and the fact that nothing comes for free in this world. Some parents may disagree with this, but in principle (probably with some sort of modification to suit the situation), I believe it to be sound.

Children—A Mirror Image

Never forget that your children will often turn out to be a mirror-image of you. This happens so often that I must mention it, and I will probably mention it many times again. The child subconsciously absorbs the attributes with which it comes into regular contact. If parental example is sloppy, greedy, selfish, unloving, cranky, always blaming the other person, overcritical, rude, immoral, then this is most likely the sort of person your child will develop into. Conversely, if the child sees love and affection, honesty, a high moral standard and happiness, as the general standard, this also will be the standard he will automatically adopt.

Downloaded from Fountain of Knowledge Library

Of course, as humans are also influenced by many facets of their environment, these comments will not always prove to be true. Other factors will interplay. But the foregoing principles are important. Use them to the best advantage you can, for as long as you can. It will pay handsome dividends.

I believe it is worth taking time to teach your child the value of setting goals for himself in life. A life without a goal is like a ship without a rudder. It will never reach its destination, for there is no destination to be reached, and no way of reaching it anyway.

To my way of thinking, a goal in life is one of the most important features. This may be applied to any facet of living. But start to inculcate the idea as soon as you can. This may be started in any child at a very young age.

Encouragement is always necessary. Help your children make plans, and get them into the way of setting targets for themselves, whether it be on the domestic level or in the academic sphere. Teach him to aim at passing exams, and to have goals in non-academic activities.

Set Goals

Established early in life, this philosophy will go with your children for the rest of his life. Every successful person has a set of goals. Of course these will be modified often, perhaps annually for major goals, or monthly, weekly or even daily for those of lesser magnitude.

But use the principle, and do your best to encourage its implementation as often as you get the chance.

Encouragement is vital. Asking how progress is being made, giving credit for success, and encouraging the youngster when the going gets a little tougher, are all necessary.

Keep an eye on the friendships your children develop. Without interfering too much, you can often make practical suggestions and offer guidance. It is pointless to tell your children that you simply don't like Tom, or Dick or Harry. This will only antagonise, and perhaps cement an unsavoury friendship. Rather, be discreet, and endeavour to use tact. The same applies when the children reach adolescence and start forming boy-girl relationships. Tact, discretion and kindliness are all essential.

It is very important to make your home as open as possible for your children and their friends. If you fear illicit relationships, make sure Junior and his friends are about the house. In this atmosphere the friendships will most likely fade. Of course you can't be your children's seeing-eye dog at all times. But you can at least offer them situations where dangers may be minimised.

How many teenagers have run into moral strife because the home was simply not available, and they resorted to the family car and got into the habit of back-alley parking (and necking and whatever)? There is no more successful way of asking for trouble (and a probable unwanted pregnancy) than back-alley, back-seat necking, particularly at night.

The risks are less at home. A home atmosphere will not hold back the rising hormonal level of your growing children, but at least it will help to hold the reins in check until they can start to make sensible decisions for themselves.

Maybe you don't like the sort of music your children play. That is sometimes a matter of taste. (My parents didn't like the sort of music I grew up with either. But I still like the same sort of music today, and fortunately at least one radio station sees fit to play the nice, soft, easy-to-listen-to type of music of my late teens.) Popular tastes come and go, and nowhere is this seen so forcibly as in the musical scene. So, today's musical tastes will be totally different fifteen years hence. My children's children (and yours, too) will be thumping out music that our kids will say is hideous. But try to live with it, and if possible, try to become part of it—as much as you can.

If you can relate to your child's interests, so much the better. Becoming involved in his school and its activities at least lets him know you care and are prepared to spend time and effort on his behalf. It's worth trudging around at week-ends to school sporting fixtures, no matter how you might hate them.

Conversely, lots of parents will get a great amount of delight out of all this. Many will relive their own school-days, and become captivated once more as they see themselves (now reflected in little Johnny) performing in the field. Once more, this is all part of the family co-operation thing. It all helps to keep the family intact and together. If you can achieve all this, you have performed a marathon undertaking, and success is yours.

Downloaded from Fountain of Knowledge Library

Chapter Four:

Marriage and Finances

Finances play a very important part in every family circle. Getting your priorities right from the start is essential. Work out a system of budgeting, and many of your problems are over before they even start. It is incredible what the average family can achieve when systematic attention to finances is taken into account. In this regard, wives can often play a major part. Husbands should never underestimate the value of a mentally acute wife when it comes to money. They can often be brilliant.

What about finances in marriage?

Take my tip. Get your finances off to a good, clearly understood start. In this way you will avoid misunderstanding and unhappiness in the long run.

Money matters commonly cause disagreements and fights. These often loom large in marital rifts and divorces. It is not hard to come to a firm understanding on the financial situation, and the sooner this is done the better. The most sensible approach is to sit down together and work out a method that suits you both.

As a starting-point, it can be a worthwhile exercise drawing up two columns. In one you simply state your income (or what is left after tax is removed). If both are working, total this, and you will then see what sort of money you are thinking about in annual terms.

Then, on the other side, set down the items that have to be paid for. Put down the fixed expenses, such as rent (or home repayments if you are buying your home), electricity, council and water rates (these are applicable if you are buying your home, but not if renting), car (include depreciation, and running), items that are on time-payment.

Add all these up and see what is left. Now, you have to live, so "x" dollars must go into "housekeeping," and another "x" into clothing. Housekeeping tends to be pretty well fixed after you have settled down into a routine. The clothing factor is a variable, and apart from certain essentials, can be varied considerably.

Now, after totting all this up, you will find that you have either a deficit or a credit. I hope it is the latter, for living on the breadline is no joke.

However, it is the "what's left" bit that is important, for it will often make the difference between living "comfortably" as they say, or living a more stringent sort of life. It depends on how these figures add up as to what your financial future is destined to be like.

Once you have a general idea of what to expect, you can then start to do a bit of extra figuring. Today, many couples still yearn to own their own home. "It is the birthright of every Australian [New Zealander, American, Briton, etc., etc.] to own his own home," the politicians glibly say, at the same time watching salaries

Downloaded from Fountain of Knowledge Library

soar and taxation rocketing to even greater heights, leaving a take-home pay-packet with a greatly reduced buying power.

Dream Home

The fact remains that home ownership is still the dream of most, and if it is at all possible, the idea should be encouraged. Rentals paid to landlords are never retrievable. It is "dead money." Certainly the landlord has every right to get a percentage on his invested funds, so don't blame him for making life hard.

The majority of couples, even in these days of high-priced housing, should make plans as early as possible to purchase their own bit of real estate. As I watch couples marry, I find it most stimulating to see a given proportion, even in these days of astronomical prices, still purchasing (and paying off) their own homes in the early days of their marriage.

It *is* possible. But it must be planned for. Many sensible couples work hard before marriage, and accumulate a nest-egg at the bank. When they marry, they pool the funds, and this is often adequate for a deposit on a modest dwelling.

Once the deposit is paid, everything thereafter is payment off the principal (and the interest), but inevitably the principal sum is being gradually whittled down.

Generally speaking, in times of inflation, it is in the buyer's own interest to purchase and pay off. You buy today at whatever the going rate is, just suppose it to be $85,000. But you are paying it off in terms of money values over the next ten or twenty years. By then, if inflation keeps going (and it seems this way, despite what the pundits say), you are paying it off in money of tomorrow's value. In short, your income is greater, and it may take a lot less time to pay off the total principal than you had imagined. What is more, your house tends to keep pace in value with the inflationary spiral.

It is worth bearing this in mind. A smart real estate man told me a long time ago: "The best time to buy (or build) your house is *today*." Sure, yesterday or last year or ten years ago would have been better, but that is gone and dead and buried. Tomorrow's prices will be significantly more. Today is the time. Get the message, young couple, unsure of making a decision?

If you do not take the step, in twenty years' time you will still be wishing you had. By then rentals will have tripled, as well as the price of houses, and you still own nothing.

However, you must put the cost of housing well up in the list of regular "outgoings," for it is basic.

Today, every young couple seems to want the lot, as far as everyday domestic conveniences are concerned, right from the start. There is no harm in wanting.

Avoid the Traps

However, let me offer some salutary advice. Do *not* get trapped in the snare of overcommitting yourself financially. To buy today and pay later seems so easy. Time-payment plans abound. There is no doubt they can greatly assist in allowing a person to gain the essentials promptly. But so many overcommit themselves, only to find they have a financial noose around their necks that seems always to get tighter.

Often, if payments cannot be kept up, everything is lost anyway, for finance companies are not backward in repossessing if the payments are not met regularly. After all, they have done their part, and they expect you to keep your part of the arrangement. Many couples think hire-purchase companies are mean and greedy and unfair if repossessions take place. However, if they looked at the operation objectively, and considered what was involved, many would see that it was their own financial folly that led to the unhappy situation.

Let me repeat: DO NOT OVERCOMMIT YOURSELF WITH HIRE-PURCHASE OR SIMILAR ARRANGEMENTS.

It is often far better to wait a little longer. Let your bank account slowly mount up until you can buy the new furniture, the new carpets, the new fridge, or whatever. Then you will be able to make a cash purchase, and today, generous discounts are often readily available for cash buyers. Besides, you will not have to pay out the high interest rates built into every HP deal. Once more, the HP companies are offering a service, but it usually is expensive, and doing the deal yourself with your *own* money is far better and cheaper.

Another point worth considering is what to do with your money in the interim. Where is the best place to invest it if you are trying to save, to buy your house, or a car or a block of land?

Today, banks offer excellent services. Many couples find it expedient to deposit their entire pay-packet (or cheque) into the bank, and then draw out funds as they are required. For example, there will be a cheque each week (or fortnight) for basic living. There will be the accommodation cheque (rent or house repayment). All the other items will have cheques

Downloaded from Fountain of Knowledge Library

written for them too, on a regular, systematic basis. In fact, spending one night a week or fortnight "doing the finances" often makes it a simple chore. In this manner you will be doing two things. You will be making sure that all outgoings are being checked against a master list. You will not be frivolously wasting money. There will be a record on your cheque butt (and subsequently on your bank statement) as to how you disposed of your funds.

Besides being of value at the time, it also provides an accurate, readily acceptable record for the end of the financial year when you have to work out your income and expenditure for taxation purposes. It can save much time, head scratching and headaches at that time of the year.

However, keeping a cheque account going is not cheap these days. What is more, you pay the bank for the service. Savings accounts accrue interest, but at a low rate, often well below going rates and well below the inflationary factor. If you put your money there, you are steadily going backwards.

Shop around. Surplus money in your account may be much better in a building society, or similar interest-bearing place where you are getting a reasonable rate. Most of these are not keeping pace with the percentage rate of inflation either (and besides, you have to pay tax on interest earned). But at least while you are waiting to spend the money you might as well let it work for you, and get the best deal available. If you have a fairly large lump sum, putting it out on the short-term money market is often worth thinking about. They will take sums for any period of time, from one day upwards—yes, you can even accrue interest over the week-end if you want to. This is all worth considering.

In the early days of marriage, it is often convenient for both partners to work. Frequently, keeping the home (often a flat or home unit) clean and tidy only occupies a minimum amount of time, and with two incomes, the chances of amassing a tidy sum increase greatly.

Many find it best to place both pay-packets in the bank, and draw outgoings in the manner described. Some couples find it is quite possible to live completely on the income of one (frequently the smaller of the two). This allows the other's total earnings to amass. When thinking in terms of buying a house (or car, or other requisites), this is about the only way it can be done.

I cannot help re-emphasising the common sense of getting your money into some sort of account as soon as possible after you have received it from your paymaster. Often, people paid by cheque fare better, for they are virtually forced to cycle it through a bank account.

One thing is for sure. If you have ready money in your pocket or handbag, the temptation to spend it is overpowering. You'll suddenly see something you have wanted for ages. "I simply must have that," you say to yourself. "I've been waiting for it for years. Aren't I lucky?"

Bang goes half of your week's money. Another notch is cut in the *downward* grade of your dreams and aspirations to get that new house paid for. Spending money is like a drug with some people. The feel of it in their pockets means the temptations loom bigger and more often. Many simply cannot resist it. "Impulse buying," of course, is the way many retail businesses make their profits. They depend on thousands of people acting the way I've just described. It is probably just as well for the retail trade (and for you, too, if your income comes from serving in a shop, or some related activity). But, take care. Get your money into a safe place. Then leave it there! Do not be tempted. If you can't feel the money jingling (or the notes rustling), you will not be tempted to spend. That means your long-term dreams are a lot closer. Especially when this is multiplied many times over, week in and week out.

Reduce Your Costs

If you are really trying to conserve funds to make a major purchase (or if you are intent on paying off the house as soon as you can), there are many ways of cutting down on costs.

Although owning a car is great, it is one of the most expensive items you can possess next to a house. The running costs are huge. Early in marriage, unless a car is absolutely necessary for business needs, it is worth considering waiting for a while. When you do buy, perhaps consider a good second-hand model instead of the latest model. Lots say, "you buy the other fellow's problems if you buy a second-hand car." Probably so, but you are paying proportionately less for it than for a new one. What's more, the day you step into a brand-new car, it becomes second-hand at that moment.

Having the phone connected is great and very convenient. But is it essential right from the start? Phones are notorious for chewing up money, and gone are the days when they were a simple, inexpensive item.

Travelling to and from work is often much cheaper if you use public transport. In fact,

Downloaded from Fountain of Knowledge Library

Grateful acknowledgement is extended to the Westpac Banking Corporation for their courtesy in permitting the use of this photograph featuring portion of the interior of their branch in Bondi Beach, New South Wales.

Downloaded from Fountain of Knowledge Library

working in town can present a major problem in parking a vehicle, and that is not cheap, either. Unless it is a definite requirement to actually earning your income, it is often far better left at home—which, of course, means that it is probably unnecessary, particularly in the early years of marriage. These ideas are simply inserted as "thinking points." Some will think they are out of date, but they are not. Money is money, in everybody's language, and the more you can save for the essentials, the better. In fact, once the habit of saving is established, and after the major cost factors have been taken care of you will be in a far better position to pay off a less expensive car. Then, in due course, you will more easily be able to afford nearly everything you desire.

In today's world, with high prices, it is often a good idea if you can work out some way of augmenting the family income by outside activities. There are innumerable methods available. It is a case of sitting down and working out what you are capable of doing, then trying to find something that meets your capabilities.

These may be simple or more complex. However, to start with, do not aim too high. The idea of starting your own business might appeal. Let me inject a warning note. About 80 per cent of small businesses run by husband-and-wife teams go to the wall within one to two years. In short, they go broke. Often they absorb the total bank account as well. In the end, you are infinitely worse off than before you started. Better still, keep at your basic income-producing activity, and get some side-line going. Pick something that will reap as high rewards for the time spent as possible. Often doing jobs that produce so much per hour is fairly restrictive in the potential income they may produce. I feel it is better to select something where you get paid $x for "the job."

Over the past twenty to thirty years, real estate has been an amazing source of added income for many. Lots of young couples have bought a block of ground, probably worked on it, clearing it, fencing it, levelling it out, and then reselling it at a handsome profit. Then the experience may be repeated, and repeated, each time a substantial profit being made.

Many might claim that today such opportunities no longer exist. But for those who seek, the opportunities are always present. Often in difficult times, the greater are the number of chances, for it means that more and more people have to unload their property, or whatever.

Some young couples will buy a run-down house (on terms, or through a bank or building society), and spend all their spare time doing it up. They will work nights and week-ends and holidays, painting, patching, fixing. They will call in trades people to do essential jobs they are unable to do themselves. Finally they will have a house that is ready for resale. Then the kill comes when they receive a price which is ever so much more than the original price plus the costs involved in repairing it. Also, it often works out that they have enjoyed rent-free accommodation as well.

The combinations are endless. I cite this form of enterprise because over the past several years many young (and not so young) couples have done really well out of it.

In fact, I have watched with considerable interest several progress from virtually nothing, into a home that was finally the envy of all their friends.

"How did they do it?" "Where could a couple of kids their age have amassed the money to get a lovely place like this?" were the comments. Of course, it was not easy-come-easy-go. It was hard work for several years. But instead of making a few dollars per hour, they made a really good profit on a "per house" basis. Of course, tax cut into the picture, and took its share, but this is part of life too. There is always something left, and when the profits are in the names of two people, it levels out the tax to a certain degree. These matters may offer food for thought for couples interested in securing their own home, and as well making some extra money on the side.

The Rainy Day

However you plan your finances, always make certain that you have a little put aside for the inevitable rainy day. In these days of economic uncertainty, many suddenly lose their jobs. Even the best workers can find their positions fold up overnight. It is nice to know that you have a few dollars salted away against such an experience, for "it can't happen to me" simply may reverse itself one day, and you find yourself alone on the pavement, jobless.

Also, one never knows when sickness or adversity may strike. It is always nice to have some funds that you can call on in a hurry if need be.

Make sure that each partner has a certain amount of money "for your own personal needs." No wife likes begging for a few dollars for a new dress. Even those living on a tight

Downloaded from Fountain of Knowledge Library

budget should allow something for the little personal extras that make life livable. Birthday, Christmas, wedding gifts; the odds and ends; dental accounts; extra costs related to unexpected guests; a sudden trip that was not anticipated; things for in-laws and relatives. The list can be quite large. These things must come into your budgeting. Often, unless these things are considered and taken into account, trouble may start here and quickly increase.

Finance is often cited in divorce cases as being a big factor in breeding marital unhappiness. It is sad to see this happen, for in most cases it is totally unnecessary. A sensible partnership, working together in harmony, should be able to take care of the finances in a manner that suits both.

I must mention here that often one partner is obviously better at handling money than the other. Often it is a good idea to let the more financially astute member take care of the overall financial situation.

Many wives make excellent financiers. They frequently run rings around men, when it comes to balancing the budget, doing the banking, working out the finer details, caring for the income-tax returns, and so on. If this is so, husband, don't think your wife is "taking over." Sensible husbands will realise the value of a woman with these capabilities and happily let her take the financial reins and look after the books, often completely.

Do not think you are giving up your manliness, or masculinity, or surrendering your position as head of the house. You are not. You are being smart and merely "delegating responsibility." Most bright general managers of major businesses learnt years ago that the task of delegating responsibility is the smartest move they ever made. What G.M. could be bothered with the hack work of running the company's books? Hardly one. He is more interested in the total concept.

Get this idea into your head, and you are way ahead. Likewise, the wife shouldn't feel that she is being given a boring assignment of merely routine work. If this is her special capability, she should be proud to be able to look after the finances of the "company"—the husband-and-wife partnership. It is a responsibility of no mean order, and many women thrive on it.

In any case, the situation will often become obvious. Sharing, being sensible, being in agreement and happy with what is taking place are all very important features of the family budgeting system.

With care and common sense, virtually any married couple today can achieve most of the comfort and financial pleasures that they so desire.

Downloaded from Fountain of Knowledge Library

Chapter Five:

The Social Aspects of Marriage

There are many aspects of marriage that are grouped under this heading. They range from attitudes on sport, entertainment, occupations, in-laws, social habits, alcohol and tobacco, and religion. It is essential that some sort of agreement be reached (preferably before the wedding) on the attitude each person holds in regard to these very important factors. Otherwise, trouble may result. Don't think you will change your partner after marriage. This forlorn hope is rarely achieved.

There are certain aspects of marriage that I'd like to call the "social" ones. Such aspects are not necessarily related to money, or the actual bringing up of children, although these are implicated indirectly.

It is very important that the partners have a clear understanding of certain habits, likes and dislikes, and see that they fit into the general structure of the family circle.

It is essential that you talk these matters over in depth well before marriage. Of course, for those who are already in the wedded state, this is simply not possible. Just the same, it never does any harm to air views, express opinions, and arrive at decisions. It gives everything a clearer concept in the minds of the contracting parties.

There are many sub-topics under the very broad classification of marital social factors.

First and foremost, of course is a brief consideration as to how you came to be acquainted. Probably it was on some social function. This is the usual way in which boy-meets-girl. It may have been at work, when travelling to and from work, at church, at a church social function or work or club event. Or it may have been at the home of a friend, or at a sporting fixture. Meeting while on holidays is a popular one. I've seen couples meet on pleasure cruises, and make very stable, happy lives, despite what most would think to the contrary.

This all brings me to the next part. How do you each measure up to the social interests, customs and habits of your partner? These are extremely important considerations, which should be talked over in your serious premarital discussions. One thing, however, is quite certain. Whatever you are like before marriage, you are destined to remain that way after the wedding knot has been tied.

Are you happy with the interests of your partner? Do you like the type of friends he/she has? Are they the sort of people you would be happy to associate with for many years? Does he do the kind of things that you feel you could put up with for the next fifty years?

It's very important to make a decision on these things, for they will play a major part in your future.

Downloaded from Fountain of Knowledge Library

Is your partner sport-mad? Does he want to jump in the car at every opportunity and race off to the surf, cricket, football, tennis? Does he prefer active participation sports where he is involved bodily? Or is he more keen on sitting and watching others play?

Is he race-mad? Does he like rushing off to the races each week-end, or to the dogs every Friday night? (Where I say *he* I also mean *she*, for this applies with equal significance to both parties.)

Does he love parties? Are his friends loud-mouthed, bawdy, rude, uncultured and uncouth? Or are they pompous, over-refined, egotistical bores?

What is his attitude to alcohol? Does he regularly "get on the grog" and go on a bender every Friday night? Is his week-end usually a lost one, spent in drinking till he passes out cold? Or is he merely a moderate social drinker, having a few glasses with the boys after work each night? Or is he a total abstainer?

Once more, it is essential that you know, for these factors may have deep-seated repercussions for you both later on.

What about his smoking habits? Does he smoke at all? These days with increasing medical evidence indicting cigarette smoking as not only an anti-social custom but a definite health hazard and one of the prime causes of premature heart disease and lung disability, anybody who still smokes at all (worse still, heavily) is extremely unwise. What about your partner? What is his attitude to cigarettes?

"They haven't proved a thing. I enjoy my cigarettes. See, nothing wrong with it, and all this talk about making it illegal on public transport (in theatres, restaurants, whatever) is ridiculous." Are these the reactions and complaints you hear from him (or her)?

The point I wish to make is that there are many aspects of everyday living that will affect a person, as well as the person to whom he is married for the rest of life. It is important that these conditions are accepted—and willingly so.

If you are happy for your husband to whizz off to some sport as a regular on-going incident every week-end, that's fine. You may enjoy it, too, and go along.

If you both have similar attitudes about cigarette smoking (but I hope neither of you smoke), that's all right too, if this is what you desire.

Alcohol, whether it be at the social or high-pressure level, is a personal matter. There are numerous points against alcoholic consumption, such as the risk also of premature and more probable cardiac disease, but if you both have the same attitude toward it, that also is a personal matter.

However, over the years I have seen so many marriages come unstuck simply because the partners do not agree with their respective "social standards."

It is incredible how many women will happily marry a man, and then set about to try to change him. It is not fanny; it is pathetic. We have all witnessed this tragedy.

"Everything is fine," you hear a starry-eyed fiancée say. "Jim is really a good guy deep down. When we get married, I'll straighten him out. He'll see his mistakes, and soon change."

Heard words like those before? Probably not in such a stupid form, but in principle. We have all heard them, or at least have seen the sentiments in operation.

Unsuited Couples Marry

Often two totally unsuited persons will marry, for reasons that are incomprehensible to the casual onlooker. In many, many cases of course, the union comes tumbling to the ground. Both parties are left unhappy, and another divorce figure is chalked up in the book of statistics. The only people who win in divorces are the lawyers.

Do not imagine you will be able to alter the basic pattern of your partner after you are married. The chances, I assure you, become slimmer and slimmer the nearer the wedding-day comes.

Some cases may succeed but, in the main, disaster stalks.

If Lou has been smoking his head off for the past five to ten years or more, then he is not going to stop merely because you think he should. If he regularly drinks each night with the boys, and stays out till midnight each Thursday at the club, he is not suddenly going to alter this simply because you think he should.

If you start insisting that he alter his ways, you are also headed for dismal failure. For a time, while the initial euphoria of marriage still has him in its grips, he may. But inevitably, he will get back to the routine he has built up for himself over the past few years. It will not change. A girl who believes she has adequate strength to bring about such changes is fooling herself.

I do not mean to be unkind; I am merely stating a fact of life. I've seen too many erstwhile happy marriages (happy for the first tentative months, or maybe years) come unstuck because a girl develops into a nagger. It goes under all manner

Downloaded from Fountain of Knowledge Library

of guises. She is trying to "help" him; get him off the cigarettes for his health; off the drink because they can't afford it; because of the baby, the kids, or whatever.

It won't work. Forget it, and stop trying. Stop giving yourself a headache by battering your head against a brick wall.

It is far better to consider all these things well before you are married. Either be prepared to accept them, or reject them. In the latter case, it means you opt out, and gradually look around for somebody else who already has the set of standards you prefer.

There are plenty of fellows (and girls) who don't smoke, who don't drink, who don't gamble, who aren't club-happy, and who prefer home life to sporting life, the races, or whatever.

Find somebody with your own set of principles and likes and dislikes.

Fortunately, very often people tend to make friends initially because similar social customs throw them together. For example, those who met at the church club level tend to have, roughly, the same principles and outlooks. This is a big factor in favour of churches and the social activity related to them.

Similarly, sports-minded people will tend to catch up on the social level with those so engaged. Often the problem of cross-typing never arises, because the situation has automatically taken care of itself, and so guided your destinies.

There is no doubt that couples who are on the same wavelength with their social habits, likes and dislikes are far more compatible, and are much more likely to make a success of life than those who are not.

It is also worth checking your respective likes and dislikes in regard to entertainment, for this, too, often forms a major part in the lives of some people. Are you similar in your interests here?

It is wise to have some idea of your partner's tastes. The nearer it is to yours, the better. Few things can be much worse than being dragged along to a classical concert if you don't happen to like classical music. Neither is a popular concert the ideal place if you like Beethoven or Schubert. Do you get the general message?

Is your partner a keen bush-walker or mountain-climber? He is? And you are too? That is fine, for it must be hard to match up some likes and dislikes. Then I am sure your chances of a successful married life will be high.

Do you both like talking your heads off whenever you have social intercourse with others? Usually in any marital team, there is one who prefers to do all the talking, and the other tends to sit and listen and do the back-up. Most units do not have place for two dominating figures who both want to be in the limelight most of the time. One must inevitably suffer.

The In-Laws

How do you feel about his parents (her parents)? Do you find them interfering bores, who meddle and carry on in a way that drives you mad? Sometimes you can get away from in-laws, but often you cannot. If there is any squabble, the girl will tend to opt for her parents to back her up. They will take her side nearly every time, whether you be right or wrong.

Ideally of course, getting along with the in-laws is best. In fact, in spite of the mean things that are thrown at in-laws as a group, many of them are wonderful people, and many sons-in-law and daughters-in-law find the new relationship just great. It is a delight to see this state of affairs. Approaching it all with this in mind, of course, is much more likely to yield successful results than the reverse.

In fact, over the years I have seen the son-in-law or daughter-in-law become more attached to the in-laws than to her own parents. Somehow they "just click." It is an interesting phenomenon.

I must recount a little story that still stands out in my memory. It is a gem, and I love to think about it. It is a bit complicated, so follow carefully.

Jim and Jane both attended the university which is not far from where I practise. They were a lovely couple of kids, in their late teens. Jim's parents were pretty tough on him, and when he met Jane, he really fell head over heels in love with her. What's more, he made the grade with Jane's mother, who was a friendly person and took to Jim in a kind of mother-and-son relationship, as it should have been.

Jim spent quite a bit of his spare time there, although trying to pass examinations at university level didn't leave too much time for socialising. However, the two were at the same institution and saw a fair bit of one another, particularly after classes. I saw them from time to time, and immediately felt what a great match they would make. You know, sometimes two young people just click, and I think I clicked with them too.

However, one forlorn day they came along. I immediately suspected trouble, and wasn't far wrong.

Downloaded from Fountain of Knowledge Library

"Think I'm pregnant," Jane mumbled, with an unhappy look on her face. "I think she's right," Jim added. "It's my fault. I accept the entire blame. However, our problem now is, what to do?"

(This was in the days before legal terminations were introduced. In fact, as many will remember, because it is not that long ago, having a termination carried out for anything other than strict medical reasons was a criminal offence and could result in a gaol sentence. Besides, abortion in such a case as this is contrary to my principles; so we didn't even discuss it.)

"There is only one thing," I said. "Jane is pregnant, so she'll have to go through with it all. Either you can get married, or let Jane battle through alone, and adopt the baby out when it is born."

"What are your thoughts on marrying under circumstances as these?" they both asked. I had to tell the truth.

"Marriage entered into because you 'have to' surely isn't the best foundation for a lasting family union," I replied. "However, it is done by somebody every day of the week. It depends on how you both feel about it."

"We'll think it over," they said as they left.

A week or two went by, then Jim turned up on his own.

"I've got problems," he said. "Big problems, and I want your advice."

"What's wrong?" I asked.

"It's Jane's mum. She's cut up real rough."

"That's to be expected," I answered. "I'm not surprised that she has thrown you out and is mad at you and won't let you back in the house."

"I go along with that," Jim said. "But it's not that way. She is blaming Jane for getting pregnant, and has thrown *her* out of the house . . . literally packed her bags and told her to get lost—like on a permanent basis."

"You must be joking," I said, hardly believing my ears. I knew Jane's mother, and had always found her to be reasonable.

"As for me, I'm getting on with her better than ever. I clicked with her the moment we met, and really love the old dear—not that she's that old, I suppose.

"She has told me she is ashamed of the way Jane must have acted, and she wants me to know she bears no grudge against me, and welcomes me into the house whenever I like. 'Please keep in touch,' sort of thing. My problem is with Jane and trying to get her housed somewhere."

"What about getting married?" I asked.

"Jane's mother is totally against the idea. She flew into a rage when it was broached."

So, the unhappy pair plodded on. Jim found adequate accommodation for Jane, and paid the bills and did his share in looking after her, which in these modern times is really something. So often, when there is talk of a child, the father-to-be simply vanishes into space. I must say I admired him for his stand. What's more, he kept in close touch with Jane's mother, and did his best to lead her tactfully around to accepting the idea of reinstating her daughter.

University students well know that beggars can't be choosers, for funds are invariably scant. Relying on the home front is important when you are an impoverished student.

With Jim's tact, he finally talked Jane's mother around to accepting the idea that Jane was pregnant. In fact, she gradually became enthusiastic, and more and more overjoyed at the idea that she would be a grandmother. This would be her first grandchild.

"Things are going fine," Jim said one day when he called around to give me the latest progress report. In fact, I found myself becoming more and more involved with this lovely pair of kids in strife.

"Glad to hear it," I replied.

"Yes, Jane is back home. Her mum has fully accepted the situation, and now says she will fully support the whole thing, and in fact is really looking forward to the baby, and can hardly wait till she is a granny. How is that?"

"It sounds fine," I answered, really happy that the family was becoming reunited again.

But that is still far from the end of the story.

Disaster Strikes

About a week later, Jim called me urgently one night.

"Jane's bleeding heavily. It came on suddenly. What's more, she seems to be in a lot of pain."

Obviously a threatened miscarriage was pending. Without any delay, I organised the local hospital, and sure enough, Jane miscarried. Everything ended. She didn't suffer too much, for youngsters of this age can usually tolerate these situations surprisingly well. She needed a blood transfusion, for the blood loss had been heavy. A couple of days later Jane was out of hospital, and back into the routine, feeling a bit shaken.

"What now?" I asked, as Jim came to my surgery about a fortnight after the incident.

"You'd never guess," he replied, looking

Downloaded from Fountain of Knowledge Library

It is very important that the partners in marriage have a clear understanding of each other's habits, likes and dislikes.

downcast. "It's Jane's mum again."

"What could ever be wrong this time?" I queried, totally unable to fathom what could have occurred now her daughter was no longer pregnant, was well and fit again, and was able to continue her university course.

"Her mum had become so obsessed with the idea of the baby, and becoming a grandmother, she is now blaming Jane for trying to 'get rid of the baby,' and claims it was all a put-up job. Do you think you could come around and have a talk to her. She's thrown Jane out for the second time running, so she is back in the flat I rented for her."

"Good grief!" I said, "I can't believe it at all. Jane's mother is normally such a lovable person."

"I know," Jim said. "I'm still Number One. I simply cannot imagine why, seeing I'm basically the one to blame."

To cut the rest of the story short, the ending was a happy one. Jane's mother readjusted to the situation. Being from a family with extremely strict upbringing and moral codes, she had really taken to heart the "terrible disgrace" of Jane—as she put it. She had taken to Jim, hoping he would become her son in due course, for she had none of her own. It had taken a long time to accept the pregnancy, but then she saw her stupidity, and was prepared to accept it all and had altered (at some effort) her feelings. Finally, having accommodated her thinking, the whole thing was suddenly reversed. It was simply too much for her to bear, she felt.

But the ultimate ending to the story was that, about a year after this, Jim and Jane were married. Mother had completely adjusted to the whole thing, and had reinstated Jane for the second time. Jim was accepted as Number One Son, and Jane received equal place in her mother's love and affection.

Both completed their university courses, received their graduation degrees, and went to work. Fortunately, they took sensible contraceptive measures, and after about three years managed to get their own home. Then, to Jane's mother's delight, they produced the most gorgeous baby girl imaginable. To make her

Downloaded from Fountain of Knowledge Library

doubly happy, they named her Grace—after Jane's mother. Then her joy knew no bounds.

I still recall this story, and still see the pair every now and again, even though they have long since left my area. They are happy, successful and, as far as I know, all get along just fine with Grace senior.

However, not all mothers-in-law are like Grace.

Many husbands find that major in-law problems occur, and once started, seem to go from bad to worse. However, in the majority of cases, if an effort to get along with them is made, success usually follows.

It is a case of doing your best, hoping for the best, and seeing what eventuates. If a person makes a definite goal of getting on with the in-laws (in the event of not making the grade too well), success is nearly always inevitable.

Of course, if the situation is simply hopeless, you can always pack up and move to another town or another city. Couples have even been known to shift to another country!

Another "social factor" which is very well worth considering is religion.

Today, although religion is generally unpopular, and many seem to be opting out of it, religion plays a very important part in the lives of many people.

It is important to get your priorities right when it comes to this angle of marriage. Two things are fairly certain. Either you regard the concept of religion favourably, or you do not.

The second is that if you are favourably inclined towards it, ideally you should marry somebody who is either of your own faith, or at least one closely related. It can be courting disaster if you marry a partner who follows a faith which has strongly contrasting philosophies and practices.

What About Religion?

Most people have fairly definite ideas about religion. Many find that it fills a positive need in their life. In Western lands, it is customary to follow the Christian faith, although in other countries many other religious sects exist, and the adherents can often teach modern society something about faith and adhering to the principles one claims to believe.

The concept of religion is an ideal one, and modern society has based many of its laws on what are basically Christian principles.

If you are a regular church-attender, it is quite probable that your partner of the future attends the same church group. It is very common for couples to meet initially at church socials, or at church-type schools or colleges. I believe this is a good thing, for at least the two will have a concept of living, ideals and morals approximately the same. This may be vital, and I feel it gives the marriage a firm foundation. The risk of the marriage falling apart is generally far less.

Ideally, church-going couples should belong to the same denomination. It always fills me with some trepidation seeing two from widely differing church beliefs marrying. Trouble lies ahead. In some cases, it can bring families close to dissolution. It may not be for some years, but when the children come along, certain religious groups are adamant that the child be baptised and educated according to *their* beliefs. This may breed arguments, and rifts are possible.

It is wise to have a firm decision made well before children arrive. Ideally this attitude should be discussed and a decision made even before marriage. It is unwise to wait until trouble could flare up.

Is your partner a committed Christian or merely an "also-ran"? Does he subscribe to church beliefs merely to make you happy (if you are a keen church person yourself)? Or is it really because he too is sincere in his religious beliefs?

Going to church a few times merely to please a future partner will not last. There must be an inherent desire to be involved, to become part of the church scene. Unless this enthusiasm is present, there is not a great chance of changing your partner after marriage. As with most other things, his interest will tend to wane. Other things will take over, and you will find yourself attending church alone.

It is well to remember also that, with the passage of time, people who are interested in religion tend to become more religious. Conversely, those who are not interested in their younger days, tend to grow further away from a religious faith. However, this is not *always* so. The opposite can occur. Sometimes with advancing years, people tend to reassess themselves. "What is life all about?" they might ask themselves as they look in the mirror one day while shaving. "Where am I headed? What is the use? What am I working for? Is there something better to look forward to than just old age and a six by two foot wooden box at the far end? Is there a heaven? Is there a God? Is there something to hope for after I'm dead and buried?"

They might become interested in religion, and find that it has real appeal. There is little doubt

Downloaded from Fountain of Knowledge Library

that it gives a person something more than physical attributes to live for. I personally believe that religion and the Christian way of life have a lot to offer.

Many thinking, intelligent people accept the Christian philosophy and gain a great deal of spiritual help and guidance from it. After all, Christianity is based on the Biblical concept, and if you want some sensible, clear-cut thinking, simply read the Bible.

The language of the old King James Version may be out of date for many people. However, many modern versions abound, and some of the more recent translations are a delight to read.

A Good Cure for Depression

If you ever become depressed, if you feel that life is passing you by, or if you feel that you are not making the grade, that your difficulties and oppressions are simply overwhelming, may I suggest reading the Books of Psalms, or Proverbs, or Christ's Sermon on the Mount in Matthew (chapters 5-7).

Let me make it perfectly clear: I am not a minister of religion, and I am no fanatical religionist. I am just a doctor who has been around for quite a few years practising my profession. But I do gain a tremendous amount of help, in all facets of life, from a daily reading of the Scriptures, ideally from one of the modern translations. (I personally prefer The Living Bible, which is a simple, understandable paraphrase of the Scriptures; or the "Good News Bible," which is also an up-to-date translation that is readily understood—what's more, it can be cheaply bought nearly anywhere in paperback.)

If you are glum and gloomy, the world seems against you, things fail, and your hopes are falling apart, try this solution. You will get so much simple, positive encouragement that your problems will tend to vanish. Do this last thing at night before you put the light out, and you will

quickly slip into quiet, refreshing repose. And during the night, what you have read will churn around in your subconscious mind, and more than likely throw the answer into your conscious mind soon after awakening next day.

I'm serious! I have used this very valuable system so many times over the years that I now rely heavily on it. It rarely fails. If you have any doubts, just try it and see.

So, accept religion in its true concept, the way it was designed. Christianity is not meant to be a complicated system. It was designed for the man in the street. That was who Christ was preaching to on the mount. That includes us all.

Downloaded from Fountain of Knowledge Library

Chapter Six:

The Sexual Aspect of Marriage

Sex is a vital factor in a happy, successful, well-adjusted marriage. Unfortunately, many do not reap the rich, physically and mentally satisfying rewards that are there for the taking. Often, common sense and a knowledge of each other's needs will greatly increase the appreciation of, and success in, this delightful aspect of marriage. Here are some suggestions that have brought unlimited happiness to many married people; these suggestions could benefit you and your marriage, too.

The sexual aspect of marriage is vitally important. While it may be possible to have a happy marriage and yet not have a satisfactory sexual relationship, such a situation is the exception rather than the rule. Happiness in the marriage bond may not be entirely dependent upon the mutually satisfactory sexual arrangements and attitudes; however, in practice, to a large extent, marital contentment is usually closely bound up with this side of marriage.

There are many couples who have sexually drifted apart. Some of these may declare that they are quite content with things as they are, that they are in no need of such satisfactions as others may obtain from a sexual relationship with their partners. However, it is a matter of record that such relationships are fragile at best, for one or the other (or sometimes both) of the marriage partners will come to the place when they tire of this arrangement, and it is not long before a secret liaison is established with someone else. In other words, it is easy to fool ourselves that we have no physical and emotional needs which are normally satisfied with a sexual relationship within marriage; but literally millions of couples have proved that, by adopting this attitude they have done themselves—and their marriage—an irreparable disservice.

For those who have found a satisfying relationship with their marriage partners, the sexual side of marriage almost invariably demonstrates the fact that this very thing which is often abused, scoffed at and made light of, is fundamental to the smooth operation of the marriage and an integral part of the warmth of companionship that true marriage is founded upon.

An Emotional Experience

Sexual union has been declared by some (mainly, it is true, by those who belonged to a by-gone era) to be morally defensible only for the procreation of children. Such a view is not generally held today. Indeed, very few would subscribe to such an idea. It is true that sexual intercourse is the only way by which a child may be eventually added to the family; but sexual

Downloaded from Fountain of Knowledge Library

intercourse has other purposes. It can be, as any married couple will tell you, a wonderful sedative and a delightful tranquilliser. It can also be a satisfying emotional experience, one which brings the couple into closer harmony, and one which binds them closer physically, mentally and, if indulged in with due propriety, spiritually.

It is becoming increasingly evident (with the alarming escalation of divorce among the peoples of the Western world) that there is much more planning done for the wedding than there is for the marriage. That is a pity, for the wedding lasts for but a few hours at the most; a marriage is supposed to last for a lifetime.

Adjustment is the name of the game in marriage. It is impossible for anyone to know *everything* about his or her partner until they have lived together for many, many years. Indeed, many people claim, after many years of wedded bliss (?), that their spouse becomes harder to understand with every passing year! Quite frequently, this is one of the great puzzles of marriage. Those who should grow closer to one another as they live under the one roof are often found to be developing different interests until they have little in common but their children and their physical encounters. And, in such cases, the latter become less and less significant.

Some of the greatest tragedies in marriage occur because of ignorance. Not so much these days, but a generation or two ago it was quite common to have a bride go into marriage quite ignorant of the basics of reproduction, to say nothing of an equal ignorance of the possibilities of the satisfaction and joys of sexual union! However, while they may be rare today, such unfortunate marriages do occur! It is then that one cannot but feel sorry for both parties.

To obviate such a potential disaster, both the prospective marriage partners ought to avail themselves of some tried and proven book on the sexual side of marriage. (A list of recommended books is given at the end of this chapter.) Preferably, they ought to read such a book (or books) together well in advance of the actual wedding day. Moreover, they should make preparations for their marriage by attending marriage counselling sessions (with an experienced counsellor or, as is increasingly done, with the minister who performs the ceremony). They should avail themselves of pre-marriage counselling classes, if such are available. All these factors assist in the adjustment which the first year of marriage will demand to be made.

Such sessions and/or classes notwithstanding, many marriages fail because, in practice, there is a failure in the sexual aspect of the partnership. This is no myth. Over the years I have spent endless hours discussing intimate sex problems with women (and frequently with their husbands). They come with sullen disappointment, often, because what they had been led to believe was a pleasurable experience has turned out to be a virtual non-event, a frustrating exercise in selfish demand. How can it be possible that sex is all the magazines say it is, and their friends tell them it is, when all they are getting is cranky with one another?

Unselfishness and Consideration

How often I have had a disgruntled wife complain of her demanding husband and his selfish insistence, and how—after he has been satisfied—he has merely turned on his side and snored off to sleep in one minute flat, leaving her there, wide awake, frustrated, irritated, unsatisfied, and, as they say, "feeling used." I am certain that this is not how it was meant to be, and I am equally certain that no marriage can be entirely happy with this attitude by one partner.

The most important factors in a satisfactory sexual relationship in marriage are unselfishness and consideration. Unless these two vital components are present in a marriage, it will be torn asunder with many problems, and those of the bedroom will be but the tip of the ice-berg.

And while wives complain of the lack of these attributes (among others), their husbands are also quick with their list of complaints: their wives do not understand their physical needs; they are inert participants, caring nothing for the role they should be playing; that their wives are (and this is the ultimate complaint) frigid!

Well, I tell these men that there are no frigid women; there are only bad lovers—and hence the blame lies at their door. That doesn't win me any popularity polls with the males, but I do not leave them at that. I try to show them how many wives have to be educated into being a good partner in the marriage bed; I try to emphasise how important it is for them to be thoughtful for their wives' needs; I try to show them how easily they (the men) can be aroused sexually, and how slowly a woman is aroused, and thus patience and gentleness and consideration and thoughtfulness and technique are all necessary components of the successful and mutually satisfying sexual encounter.

Downloaded from Fountain of Knowledge Library

Downloaded from Fountain of Knowledge Library

That is why I tell them—and now I am telling you—how important education for this aspect of marriage is. Sexual satisfaction is not something that comes naturally, in spite of what may be popularly believed, and what the glossy magazines tell you. It is something that has to be worked at diligently and patiently. So many think that, because sex is a natural instinct, the satisfaction that it is supposed to bring, also flows on as a natural by-product. Not so!

It is essential that each partner understands the anatomy of the other. And what is more, they must understand their own—and please do not take it for granted that you know this. You should know the areas where tactile stimulation (i.e., stimulation by gentle touching) will bring the best and surest results. These are built into our bodies by a thoughtful Creator who implanted within us, I believe, the sexual mechanism, and its capacity to be aroused, and the resultant pleasure that intelligent and thoughtful stimulation can bring.

All normal, healthy humans within certain age limits should be capable of a very satisfying sex life. All should be capable of achieving a climax, or orgasm, as the correct term is. Ideally, this should occur in the husband and wife simultaneously, but it does not always happen that way by any means; however, satisfaction does not depend on an orgasm (especially in the woman) at all times. She is often capable of satisfaction as a result of the stimulation and the warm glow that results from the togetherness of the love-making.

As I said earlier, it is essential to recognise the physical (and emotional) nature of your partner. Some (of both sexes) are quickly aroused; others are aroused only very slowly. Here is where patience, technique, consideration and gentleness are so important. Usually, it is the male who needs these qualities especially.

Often, for example, it is the male who desires sexual intercourse more frequently than does his wife. Here again is where his patience and thoughtfulness come to the fore; he must understand this, and not demand his "conjugal rights" as often as he might have the desire. On the other hand, the wife must know that her husband can be quickly aroused and can quickly come to an orgasm. She will need to give much thought to that.

Erotic Zones

A study of the erotic zones of the body is also of great importance. A husband should know that the nipples and the areas immediately surrounding them are well endowed with delicate, sensitive nerve-end organs. They are sensitive to gentle tactile stimulation. The supra-pubic region (between the pubic bone and the navel, where the pubic hair is located) is also sensitive. The outer parts of the thighs are likewise sensitive, along with the ear, the ear-lobe, the neck (especially the nape of the neck). These differ from woman to woman, and it is the husband's responsibility to find the area of greatest response.

Of course, it should be clearly understood that none of these areas are the most sensitive. However, they should not be neglected; they should be the focus of attention before the supremely sensitive areas are stimulated. The closer one gets to the vulval region and the vaginal entrance, the more sensitive the area and the more responsive the reaction. The inner surfaces of the thighs, for example, are more sensitive than the outer areas, but nothing is quite so sensitive as the clitoris. This is the very small organ (of varying size, but hardly larger than a pea) located a short distance above the vaginal opening. Often it is necessary to gently part the outer lips of the vulva (called the labia major, or outer lips) to gain access to it.

In the clitoris are millions of ultra-sensitive nerve-end organs that are receptive to gentle, tactile stimulation. It should be stressed that time should be taken over this period of arousal. It cannot be repeated too often that a woman is not sexually aroused as quickly as is a man, generally, and it is axiomatic that, the more the wife is aroused, the better for both husband and wife as the climax to the time of love-making approaches.

Every husband should show the utmost consideration for his wife's wishes in this most intimate moment of marriage. If there is some aspect of the fore-play or the act of intercourse itself that she does not like, the husband should be quick to abandon this, and concentrate on those aspects of the love-making process which she appreciates and enjoys. The husband should treat his wife at all times (in bed and out of it) with courtesy, consideration and deference; however, at no time should she feel more loved, more the centre of his affection, more an object of love than when the husband is bringing her to the climax of this most tender of emotional experiences.

Couples who truly love each other will have but one desire basic to their moments of intimacy; it is that the other should experience

Downloaded from Fountain of Knowledge Library

the very greatest pleasure. Never should intimacy be indulged in so aggressively by either husband or wife that the other feels used—a mere sex object. Never should there be an ending to the love-making when one or the other (or both) feel frustrated, emotionally drained or wretchedly unsatisfied. It is true that, in the early days of marriage this unfortunate state of affairs can occur, but here is the supreme example of the need for courtesy, consideration and common sense. Here is where communication—frank, open and honest discussion between husband and wife—can clear up a multitude of problems and set the course for what should be the ultimate experience in marriage.

Each Partner Teachable

From what I have said so far, it will be assumed that the husband is always the "aggressor"—it is he who initiates the intimacy which culminates in intercourse. It is true that the husband is generally the one who is the gently dominating figure, but it should not be assumed that this is an unalterable rule. In fact, it is a pleasurable change for the roles to be reversed occasionally. Let the wife stimulate her husband, bringing him to the zenith of his sexuality. She must learn where her husband's sensuous areas are, and how they can best be stimulated for the maximum of enjoyment. The penis, of course, is the male equivalent to the clitoris, being by far the most sensitive area of tactile stimulation. In many of these matters, husbands and wives must teach each other which things they desire, do not care for, and how they wish their partner to act. Each must be teachable, each must be prepared, likewise to teach. The learning-teaching experience is, or should be, as pleasant and profitable as any part of marriage.

It is desirable that both husband and wife should have orgasms simultaneously. That is the ideal; however, it more often happens that the husband will come to his climax first; he should not allow his wife to suffer by this, and he should put forth every effort to see that she is satisfied with the sexual experience. It is important to understand that not every such adventure will end with an orgasm for both. Usually the husband will come to orgasm but his wife may not. This need not result in that let-down feeling that so many women experience; properly attended by her loving spouse, even without the thrilling climax, the wife can know the delight of the afterglow of the sensuous occasion. This she will enjoy as she lies in her husband's arms.

Much can be spoiled or brought to the peaks of delight by technique. The complaints of wives who have husbands who rush the proceedings, who come to their own climax without much concern for their wives, and who are sound asleep in thirty seconds after it is all over while the unsatisfied wife lies there wondering what it was all about, ring in my ears, for I have heard such complaints so often. I cannot urge too strongly the men of this world to consider, in this, the most potentially pleasurable of all experiences in marriage, the great rule of: Care, courtesy, common sense, consideration and communication.

The Spoilers

There are many factors which will spoil the delights of sexual intercourse, and I must detail these for you before this chapter closes. I shall outline them briefly, and will not comment too much upon them. Most of them will need nothing more than a mention. The chief are:

a. Your state of health and that of your partner.
b. The use of certain drugs, even the "popular" drugs which are known as sedatives and tranquillisers. These suppress normal sexual responses. Certain drugs used for the treatment of high blood pressure often reduce the libido, and in males can reduce potency and the ability to gain satisfactory penile erection.
c. Alcohol and alcohol-based beverages may inhibit sexual performance and/or satisfaction. (In the early stages of alcohol consumption, desire is often increased, but rarely, if ever, will it increase performance.)
d. Certain diseases affect sexual desire and performance. Diabetes is perhaps the best known and the most common one, and it may affect quite young people. If you are in this group, a frank discussion with your doctor could help greatly. However, it is often the case with the diabetic, unfortunately, that treatment is not always satisfactory.
e. Overwork, increasing worries with work situations, long hours with inadequate sleep and rest, domestic tension, are also barriers to achieving full sexual response and satisfaction.
f. Impotence. This may be due to psychological factors as well as to physical. If this is your problem, you should see your doctor; he may be able to help. Often what seems to be a physical cause is psychological—e.g.,

Downloaded from Fountain of Knowledge Library

a sense of guilt—which will somehow interfere with the body's internal programming, and the result is the inability to achieve success in this important area of marital relationships.

If there are any difficulties in a marriage because of what appears to be, for want of a better name, sexual incompatibility, I would urge a visit to a marriage counsellor, your family doctor or to a psychologist trained in this field. Go to your doctor first, and it is likely that he will refer you to a psychologist or a counsellor.

Finally, don't overlook the reading of some good books on this vital area of family living. I have appended to this chapter a list of books which should be available at most bookstores.

RECOMMENDED READING

The following list is by no means comprehensive. Most of these titles I have found to be helpful in counselling. I have recommended some of these to people who have had certain difficulties, and they have been helped by them. Some are paperbacks which can be easily obtained and are reasonably priced; a few give a complete treatment on a more academic level, nevertheless, are quite readable. There is a salting of Roman Catholic and Protestant Christian authors, as well as those of no known

Downloaded from Fountain of Knowledge Library

religious slant. To help in the selection, I have sometimes indicated a high recommendation. The following notations might be of some guidance:

[1] Available at the publishing house which publishes this book.
HR Highly recommended for all-purpose, general reading.
Rep Known to me by reputation only.
RC Author a Roman Catholic.
TB Text book, but very readable for the general reader.

Beardsley, Lou, and Spry, Toni: *"The Fulfilled Woman."* Irvine, California: Harvest House, 1975. (Rep.)

Berg, Louis and Street, Robert: *"The Basis of Happy Marriage"* (The Art of Sexual Relationship) London, England: Mayflower Paperbacks. (HR)

Burnard, Don: *"Toward a Life of Loving."* Melbourne: Hill of Content. 1975. (RC)

Cartland, Barbara: *"Living Together."* London, England. Frederick Muller, Ltd. 1965. *"Sex and the Teenager."* London, England. Frederick Muller, Ltd. 1964.

Chesser, Dr. Eustace: *"Women and Love."* London, England. Jarrolds Publishers (London) Ltd. 1962. (HR)

Christenson, Larry and Nordis: *"The Christian Couple."* Minneapolis, Minnesota. Bethany Fellowship. 1977. (HR)

Cooper, Darien B: *"We Became Wives of Happy Husbands."* Wheaton, Illinois. Victor Books. 1976. (Rep)

DeJong, Peter, and Wilson, Donald R.: *"Husband and Wife."* (The sexes in Scripture and Society). Grand Rapids, Michigan. Zondervan Publishing House. 1979. (HR)

Dobson, James.: *"Hide and Seek."* Old Tappan, New Jersey. Fleming H. Revell, 1974. (Rep): *"What Wives Wish Their Husbands Knew about Women."* Publishing details as above. 1978. (HR)

Fishbein, Dr. Morris, and Kennedy, Dr. Ruby Jo Reeves: *"Modern Marriage and Family Living."* New York. Oxford University Press. 1957. (545 pages.) (TB)

Greet, Kenneth G: *"Guide to Loving."* London, England. Hutchinson and Co. Ltd. 1964.

Hardisty, Margaret: *"Forever My Love."* (What every man should know about his wife.) Irvine, California. Harvest House Publishers. 1975. (HR[1])

Henry, Joseph B.: *"Fulfillment in Marriage."* Old Tappan, New Jersey. Fleming H. Revell, 1966.

Jewett, Dick: *"Sex Is Not to Lose Sleep Over."* Mountain View, California. (Sub-titled, "A Search for Sexual Sanity. Other books tell you how. This one is Why.") Pacific Press Publishing Association. 1979. (HR[1])

Klemer, Richard H.: *"A Man for Every Woman."* New York. The MacMillan Company. 1959. (HR)

Knight, John F.: "Everything a Married Couple Should Know." Warburton, Victoria. Signs Publishing Co., 1981.(HR[1])

LaHaye, Tim: *"How to Be Happy Though Married."* Wheaton, New Jersey. Tyndale House, 1968.

LaHaye, Tim and Berverly: *"The Act of Marriage."* Grand Rapids, Michigan. Zondervan, 1976. (Rep)

LaHaye, Tim and Beverly: *"Spirit Controlled Family Living."* Old Tappan, New Jersey. Fleming H. Revell. 1978. (HR)

Landis, Paul H.: *"Making the Most of Marriage."* New York. Appleton-Century-Crofts. 1965. (TB)

Leeton, Assoc. Prof. John: *"All about Birth Control."* Melbourne. Thomas Nelson. 1974. (HR)

McNamara, Clarice and Newcomb, Jean: *"Common Sense about Marriage."* London. MacMillan and Co. 1961.

Osborne, Cecil G.: *"The Art of Understanding Your Mate."* Grand Rapids, Michigan. Zondervan Publishing House. 1976. (HR)

Peale, Norman Vincent: *"Sin, Sex and Self-Control."* Kingswood, Tadsworth, Surrey. The World's Work. 1965

Rayner, Claire: *"People in Love."* (A Modern Guide to Sex in Marriage.) Melbourne. Sun Books. 1969. (HR)

Sheen, Fulton J.: *"Three to Get Married."* London. Blandford Press. 1951. (RC/HR)

Stone, Hannah and Abraham: *"A Marriage Manual."* Sydney. Angus and Robertson. 1968. (HR)

Timmons, Tim: *"God's Plan for Your Marriage."* Grand Rapids, Michigan. Baker Book House, 1978.

Wilson, Colin: *"Sex and the Intelligent Teenager."* London. Arrow Books Ltd. 1966.

Wittschiebe, Charles: *"God Invented Sex."* Nashville, Tennessee. Southern Publishing Association. 1974. (HR[1])

Downloaded from Fountain of Knowledge Library

Chapter Seven:

All About Family Planning

Today, simple measures for effective "family planning" are readily available to every couple. It is also termed "birth control" or "contraception." Many workable systems are available, being effective, safe and reversible. New ideas are also being considered. For those wishing permanent infertility, simple measures are available for them too. Here is a full, up-to-date appraisal of the methods at your disposal.

Today, more than at any time in history, families are able to "family plan." In short, this means that they can effectively decide if they want any children or no children. They can elect to have whatever number they like. They can work out how the children will be spaced—annually, two, three, four years apart, or whatever.

Never before have couples been in this happy situation. In one sense that is right, and in another it is wrong. In the pre-Pill era, when contraceptive techniques were chancy, to say the least, there was always the lingering doubt as to whether the procedure was effective.

Today, with the very reliable methods of contraception freely available, family planning (birth control) is an exact science. Most newly marrieds are well aware of it, and embark on methods that suit their needs, starting usually a few months before marriage, to make sure that they will be "protected" (if you care for the word) right from the first.

In the pre-Pill era, it was a well-known fact that the majority of marriages resulted in pregnancy within the first twelve months. Of course, many girls married because they "had to." Even this has changed in today's permissive era, and more and more girls who are foolish enough to become pregnant out of marriage, prefer to keep their babies, but do not marry the baby's father "just to give it a name."

Australia's birth-rate today is around the 250,000 babies a year level, having been fairly static for the past few years. New Zealand has about 45,000 babies annually. The "high" came in 1971 when Australia's total soared to 276,362. This was probably an overreaction following the war years. But it was to be short-lived, as the Pill came into greater popularity, and the early adverse effects were overcome. The rate fell, and now it is hovering at a fairly constant level.

In the main, it may be said that most babies born today are "wanted," or "planned." For those of us who probably came from families in excess of two, the thought of the Pill is a little mind-blowing. What if the Pill had been around a few decades earlier than it was? The truth of the matter is, of course, that many of us would not be here at all.

Downloaded from Fountain of Knowledge Library

An interesting view of this was printed in the *British Medical Journal* not long ago. It seems that many of history's geniuses came from large families. Frequently they were well down the list, say number ten or twelve. Simpson, the mental giant who invented anaesthesia, and others are cited as cases in point.

Imagine the loss to mankind if the Pill had been available at their time of life, and they had not been born! It all amounts to this: Today, families have within their grasp very satisfactory methods of spacing or limiting their children.

Let's now have a look at what these possibilities are.

The Pill

First and foremost is the contraceptive pill, which burst on a startled world in the late 1950s. This is the most striking advance ever made in this area, and never before in history have so many women taken regular medication for non-medical reasons.

Basically, the Pill consists of two naturally occurring female body hormones. One is called an oestrogen, and the other is called a progestogen, or simply gestogen for short. Both of these hormones are produced by the female ovary in a set pattern. Oestrogen is produced right throughout the menstrual cycle. Progestogen (or the natural hormone progesterone) is produced from the date of ovulation, usually fourteen days before the onset of the next menstrual period, until the period actually starts. If pregnancy does not occur, then production ceases until the same time the next month.

However, the combination of these two hormones in a certain ratio, and taken orally on a regular basis, usually twenty-one days per twenty-eight, prevents the female egg from being released at the time of normal ovulation. With no egg, it does not matter how many male sperms are present, conception simply cannot, and does not occur.

The normal way of taking the Pill is to start on the fifth day of the normal cycle. One per day is taken, and this is continued for twenty-one consecutive days. At the end of this time, a break of seven days occurs, during which time no Pill is taken. After seven days, a new packet is commenced, and one a day taken in a similar manner. This method is continued non-stop for as long as the woman wishes to remain infertile, and desires not to conceive.

Provided the Pill is taken strictly along these lines and there is no variation, it is virtually 100 per cent effective. In the rare instances where pregnancy has taken place, a check will often indicate that certain incidents occurred. For example, the woman may have been ill, had vomiting or diarrhoea, in which case the Pill may have been vomited, or passed through the bowel without being absorbed. Protection for that menstrual month then lapses if two consecutive pills (or even, at times only one) are missed.

Some women taking medication for other purposes may have the efficacy of the Pill reduced or totally destroyed by the action of the other medication working through the liver system. This is notoriously so when the anti-T.B. drug rifampicin is taken. But several others have also been incriminated. If any other medication is being prescribed, it is worth checking with your doctor to make sure that the two are compatible.

In Australia, the usual pill is the so-called "combination pill" which is the one described. Once it was popular to use so-called "sequential pills," one hormone being taken, then the other being added for the final week. However, these fell into disfavour some time ago when it was claimed they may cause breast tumours in experimental animals, and they were subsequently removed from the medical market.

Another pill, often referred to as the "mini-pill," is a gestogen-only preparation. It works slightly differently. Its method is claimed to alter the mucus at the uterine cervix and impede sperm penetration of the cervix and uterus, and so prevent pregnancy in this manner. However, several side-effects may occur, especially related to heavy or irregular bleeding, and it is usually reserved for women under certain circumstances who find the ordinary combination pill unsatisfactory. Medical guidance in this respect is advised.

The Pill has had a stormy history, and is not without its ups and downs. Nevertheless, it seems to suit the majority, and is undoubtedly the simplest reversible method of contraception available world-wide today. In Australia about 1,000,000 women, and in New Zealand about 300,000 women regularly use the Pill. World-wide the figure is in excess of sixty million.

Side-effects of the Pill

The side-effects of the pill have often been documented. There are effects attributable to the oestrogen component and those blamed on the progestogen content.

The oestrogen component may produce some or all of the following side-effects: menstrual migraine, and increased risk of blood clots

Downloaded from Fountain of Knowledge Library

forming, and increased blood pressure; a weight increase due to salt and fluid retention; slight breast development. Indeed, this may be quite pronounced, and many younger women poorly endowed by nature often take the Pill essentially for this reason.

There may be an increase in the fat deposits around the buttocks. Often leg cramps appear, which are usually worse at night. Nausea and depression are fairly common. Some women notice a reduced sexual desire, a rather ironical side-effect when it is considered what the Pill is intended to provide—normal and free sexual intercourse without the risk of pregnancy. Many take the Pill, and find they no longer have any sexual desire in any case, which makes the entire exercise redundant. This has often led to marital disputes, the male, believing his wife is "protected," and is just being mean and unco-operative in refusing to participate in what he believes is a normal part of marriage—sexual relations.

Often the vaginal secretions are increased. This may reach a stage where it can become embarrassing. Suppression of lactation occurs, and this is more likely to be seen when the Pill is re-started after a confinement.

On the other hand the progestogen content of the Pill can also create its own set of side-effects. Often there is an early weight gain. Frequently there are nervous reactions such as depression, irritability, chronic fatigue, and a loss of interest in normal sexual activity. Often this lack of interest increases progressively as the Pill is continued. These side-effects are much like those induced by progesterone formation before a normal menstrual period occurs, in the so-called "pre-menstrual tension" syndrome which will be discussed in another chapter.

If the patient suffers from facial pimples, these are invariably worsened. (Similarly, in the non-pill-takers, pimples are notorious in the week preceding menstruation.) There may be an increase in "breakthrough bleeding" (that is, bleeding occurring part way through a packet of the pills).

In many women, blotchy markings appear on the face and parts exposed to the sun. This is termed "chloasma." It may look unattractive and can upset some women who are self-conscious about facial skin appearances. It may also appear on the abdomen, chest, back, and old surgical scars. Usually the areolar area—the normally pinkish area surrounding the nipples—turns a darker shade also. When this occurs, it remains darker for the rest of one's life. Incidentally, this occurs about the third month of pregnancy as well, and occurs for the same reason in women who have not taken the Pill before. Often there may be delay in re-establishing normal menstrual periods after the Pill has been discontinued. This is often a very worrying problem, and will be further considered later on.

Changing Dosage

So, it may be seen that there are many side issues to be considered. In the early days of the Pill, there was a tendency to use high doses of the hormones. However, after the scares of the early sixties in which several persons died from blood clots affecting the brain, eye, heart and other regions, the amounts of each were gradually reduced. It was found that the effectiveness of the Pill was still about the same.

Today, there are a great many different brands available, and each contains various amounts of each component. The oestrogen pill has been subject to greatest scrutiny. Today, instead of the 100 mcg dose which was originally in vogue, amounts of 50 and 30 micrograms (mcg for short) are in use. In Britain, there is a pill containing 20 mcg under assessment, and this may ultimately become the one of popular choice.

However, many women find that, despite the small doses and lack of side-effects, there are still many reasons why they prefer to stop this form of contraception. A study some time ago indicated that of those stopping the Pill, the following reasons were given.

The weight increase was the reason in 35 per cent of women. Headaches (often severe, migraine in nature) were put forward by 31 per cent. Reduced libido and sexual enjoyment was the reason with 27 per cent. Depression was put forward by another 21 per cent.

Even today, with the very-low-dose pills, side-effects are still being reported, and women are looking for alternative methods. However, it must be pointed out that this dissatisfaction has greatly reduced since the formulations were altered.

Pill Must Be Prescribed

The Pill in Australia must be prescribed by your family doctor or gynaecologist. It is not possible to buy it over the counter, although in some countries there is a move for this. It is believed that a proper check should precede each new six-month prescription. This should include

Downloaded from Fountain of Knowledge Library

The practice of family togetherness, so enjoyable when the children are teenagers, should be started early.

a full check of the patient's blood pressure, check for bruises or migraine, or other adverse side-effects.

Also, a breast check should be carried out, and a pelvic examination. At set intervals, too, the smear test of the uterine cervix is often carried out at the same time. It is a very convenient time for this to be done.

If there are any problems when taking the Pill, they should be discussed with the doctor. It is not necessary to wait until you see him again for your next supply if problems occur. See him at once. Often a brief explanation, or medical examination if there is any query, will discover the cause, which may be corrected. Sometimes, when side-effects are being experienced, switching to another brand may solve the problem. Many doctors prefer to use brands which are low both in dose as well as biological activity, believing these are probably less likely to produce side-effects and may even be safer.

Post-Pill Amenorrhoea

However, whenever nature is being thwarted, there is always likely to be a problem. This applies to man's efforts at preventing pregnancy. One of the most worrying, quite unrelated to common side-effects, is a condition commonly called "post-Pill amenorrhoea." In short, it means that when a couple decide they wish to reproduce, the female stops the Pill, and normally expects to see an immediate return of menstruation. If this occurs, of course, it shows that ovulation is occurring again, an essential prerequisite for conception, and the chances of becoming pregnant are back to normal.

But a significant number of young women, and the number appears to be slowly increasing, now find that normal menstruation simply does not occur. In short, their ability to become pregnant does not return.

Until such time as ovulation (and periods) start again, it means that there cannot possibly be a baby.

Until fairly recently this was a probability of no small degree. However, various measures have become available. A medication aimed at re-establishing normal ovulation is a preparation called bromocriptine. Given in a certain manner,

Downloaded from Fountain of Knowledge Library

this can readily make menstruation recommence, and pregnancy may follow very quickly, often within a few months.

It has been found, with the newer methods of measuring body blood chemicals and hormones called radio-immunoassay, that a hormone called prolactin, produced by the pituitary gland of the brain, can inhibit ovulation if present in high levels. These high levels are common in women taking the Pill, and it persists afterwards, often for many months or even years. It does not matter how long the patient is taking the Pill, the same effect may occur. It has been found in trials in women taking it for as short a time as three months. At the other end of the scale, it has been found in other women who have been constantly taking the Pill for fifteen years.

However, bromocriptine is the prescribed treatment for women with amenorrhoea.

Other Treatments

Other medications have also been used in an effort to induce fertility, including clomophene and gonadotrophin. However, these two are well known for their ability to cause pregnancy, often in multiples. In Australia, an apparently infertile woman produced a pregnancy consisting of ten foetuses at once, reportedly after being treated with one of these drugs. This was in the time before the advent of bromocriptine.

The point of all this is to indicate that if amenorrhoea takes place, there is a suitable form of treatment available. See your doctor and have a talk to him. He will most probably refer you to a specialist obstetrician, gynaecologist or infertility clinic at a large hospital for assessment and treatment. It is not to be undertaken lightly, for these products are powerful and must be given only under adequate skilled medical supervision. It is in the realm of the specialist.

Women on the Pill often notice a marked reduction in their menstrual bleeds. It may reduce to half a day or even less. The blood may be dark or even black. It is pointed out that this is all within normal limits. The bleeding is not a true menstrual bleed, but is referred to as "withdrawal bleeding," and is due to the sudden withdrawal of the hormones. So do not be alarmed if this happens to you. In some women, menstruation stops entirely.

Many women ask if it is possible to gain a few days free from bleeding altogether. Some wish to pre-plan the possibility of menstruation in relation to some important function (often their wedding day in girls newly put on the Pill). But it may be some important social function, or whatever.

The answer is that if the Pill break comes when you do not want any bleeding, simply starting the next packet of pills without any break at all, will guarantee you no menstrual flow. In fact, bleeding will take place only about three days after the last pill has been taken. This is a handy little hint to keep in the back of your mind. It is harmless, and quite reliable.

Other Methods of Contraception

Quite apart from the Pill, several other methods of contraception are also available, and some of these are relatively popular.

Some women do not like the concept of the Pill, believing it has not been around for a sufficient number of years for its true probable long-term effects to be really established. They have horrible forebodings that it may cause cancer later in life, or probably in their next generation. Although there is no basis for this on today's knowledge, their views are nevertheless appreciated. But the big problem comes when they ask about alternative forms of contraception.

The next most widely practised method in the Western world is at present the intra-uterine contraceptive device, commonly referred to as the I.U.C.D. or simply I.U.D.

The concept has been around for fifty years or more, and past models, formed mainly of metals, were in use about fifty years ago. The most widely used was the Graafenberg ring, but this fell into disfavour because haemorrhages occurred as well as infections.

But with the advent of the plastics era in the late 1960s, a new form of the I.U.D. suddenly caught on. Plastic is very well tolerated by the body, which tends to shed it far less readily than other substances. Thus the current models were hatched. Some of the early devices were not very satisfactory but many modifications have since taken place. Now, smaller devices, frequently with a fine filament of copper wire wrapped around them, are used with considerable success.

In fact, they have been given the official recommendation in Australia, and most Western countries use them widely. The presence of the device, often shaped like a figure "7," has several effects. These are enhanced by the copper which gradually is shed into the uterine cavity. Not only does this kill male reproductive cells, but the device itself helps check products

Downloaded from Fountain of Knowledge Library

of conception from being embedded in the endometrium, the lining of the uterus, which happens in normal pregnancy. In short, pregnancy is prevented in many cases. If it occurs, what many claim is a miscarriage, takes place. Whatever the mechanical reason, the pregnancy rate is reduced, and protection for the woman is greatly augmented.

Some women find it a good idea to use a spermicidal cream or jelly for additional protection at the time when ovulation is due. This is when pregnancy risks are at their peak. It could give the method additional efficacy, and may be worth while in those choosing this form of protection.

It is essential that the device be very accurately and carefully fitted, preferably by a competent gynaecologist. It seems that if not placed in the exact place where it should be, its efficacy wanes considerably.

Side-effects of the I.U.D.

There are various known side-effects of the I.U.D. also. It is not 100 per cent effective. In some, infections are possible, and these may continue. Some cases of sterility have been reported in women who have subsequently desired to become pregnant.

There have been several cases in which the I.U.D. has bored its way through the wall of the uterus, to become lodged in some other part of the pelvis or abdomen. In this way of course, the protective function lapses, and it could cause damage to intra-abdominal structures.

There is also an increase in the chance of an "ectopic pregnancy" occurring. This means fertilisation and early development of the embryo occurs in the Fallopian tube. This must cause problems, for the development must occur in the uterus. A surgical emergency may ultimately occur as the tube bursts with the increase in size of the foetus.

The I.U.D. has a checking device which will let the woman know that it is still in the right place. This is the "tail," which hangs from the outer cervix and may be felt with the examining finger—a precaution advised by the doctors as a regular issue. If it is missing, it means the I.U.D. may have gone astray and a medical check may be advisable. If you do not know what to look for, discuss this with the doctor and a little instruction will soon show you how to check. Most doctors instruct the patient at the time of insertion what to seek and how to go about this.

In the older, larger models, before the copper versions became available, side-effects were common. These were chiefly cramps, backache, local pelvic pain, heavy bleeding and discharges. With the advent of the mini-models these are far less common. Infections can occur, and discharges are often the sign of this. In any case, if there is any abnormality, it is wise to check with the doctor, and a pelvic examination will indicate if it is serious or not. In some cases it may be necessary to remove the I.U.D. Incidentally, copper models must be replaced at least two-yearly for continuing protection, as the copper becomes exhausted after this period of time.

Variants of the copper device are currently being assessed. One released a gestogen hormone regularly and is claimed to be highly protective. No doubt other types will flood the market in due course, just as the Pill variations exploded in the earlier years. After all, it is such an attractive market that many major commercial companies just cannot resist the temptation.

However, many doctors currently do not favour any sort of I.U.D. Low-grade infections may occur, and it seems these may impair later fertility. Although they are popular, their track record is not good, and some gynaecologists simply refuse to fit them. If they do, they are often inserted under a general anaesthetic in hospital.

One device called the Dalkon Shield was popular for a while, but it seemed to be associated with many infections, several occurring during pregnancy, causing "septic mid-trimester abortions." This has since been removed from the market.

Many women ask what should be done if pregnancy occurs during the use of the I.U.D. The recommendation is to see your gynaecologist at once. Advice currently varies, but at time of writing, the British journals were recommending legal termination of pregnancy,

There have been a few reported cases of congenital malformations in babies born with I.U.D.s *in situ*, and this has probably influenced this opinion. But, go and see your doctor at once if pregnancy is suspected—in short, if you miss a period. If periods are very heavy, or light, or if any unusual symptoms take place, of any nature, the same principle holds. Visit the doctor for a complete examination.

Some women still use the diaphragm. This is a round spring, covered with a thin sheet of rubber. When inserted high into the vaginal tract, it is hoped to seal off the cervix mechanically and so prevent the penetration of

Downloaded from Fountain of Knowledge Library

sperms. Often this is used in conjunction with a spermicidal cream or jelly, or aerosol foam. Alternatively, the spermicidals may be used on their own. The protection that these offer is not as effective as the methods already discussed, but some older women still use them successfully.

A high degree of motivation must be present, and in the pre-Pill, pre-I.U.D. era, they were about all that was available. However, they are now nowhere near as popular as in a bygone era.

The Condom

The condom, or sheath, is still used, although this too has been replaced with most by other forms. It consists of a rubber sheath that the male fits over the penis in the erect state prior to vaginal penetration. The spermatic ejaculate enters a small dilated nipple at the closed end of the device. It is often used in women who are on the Pill, but who prefer to be "off it" for a month or two rest spell.

It appears to be more widely used among unmarried couples or with those whose sexual encounters are of the casual kind. At least the condom has one added function which is most important these promiscuous days. It gives both parties excellent protection against the risk of contracting or spreading venereal infections, and for that reason it is to be hoped its availability will continue. There is no hope of stamping out promiscuous living, and this, at least, is one way of reducing the national V.D. toll, which has been escalating at an appalling rate.

Doctors are well aware of the protective value of the simple condom. In fact, the advent of the Pill and its ready availability has often been blamed for the increase in V.D. Women, of all social strata, now tend to use the Pill, whereas in former times there was a greater reliance on the condom, which mechanically prevented or greatly reduced the V.D. transmission factor.

World-wide, the condom is said to be very widely used, particularly in the Orient.

The "Rhythm" Method

Another method which is often used is the so-called "rhythm" method, as well as the more accurate "ovulation method." This aims at avoiding intercourse at the time when conception is most likely, which is the fourteenth day before the onset of the next menstrual period. In many women whose periods are regular, this is easy to calculate. However, many women do not have regular periods, and this makes pinpointing the time difficult, if not impossible. Keeping calendars can help in some cases. Others have a definite warning signal in that they develop a typical low pelvic pain at the time ovulation occurs.

The ovulation method looks for certain kinds of vaginal secretions and relates these to ovulation. This method requires exceptional motivation by the partners. However, those who have used it for many years claim it is workable, provided one takes the time and makes the effort. The average woman can't be bothered, however, and under such circumstances the method will inevitably fail.

Last, but not least, on the list of contraceptive methods is that referred to as "coitus interruptus." This simply means that the male withdraws his penis from the vagina just a few seconds short of ejaculation (the climax). Great mental discipline and physical control are required for this, and many males with good intentions simply can't bring themselves to spoil the most enjoyable part of intercourse, the climactic moment. Under these circumstances, of course, the method will fail.

However, during intercourse, it is well-known that sperms may silently and unwittingly pass down the urethra to find their way into the vagina. As any doctor will tell you, it takes only one sperm to fertilise one egg. That wayward fellow might be the one that causes the pregnancy!

Oldest Method

It is believed that withdrawal is the oldest method of birth control, having been in use for thousands of years in all countries of the world. It will be practised again and again. At least it is better than nothing.

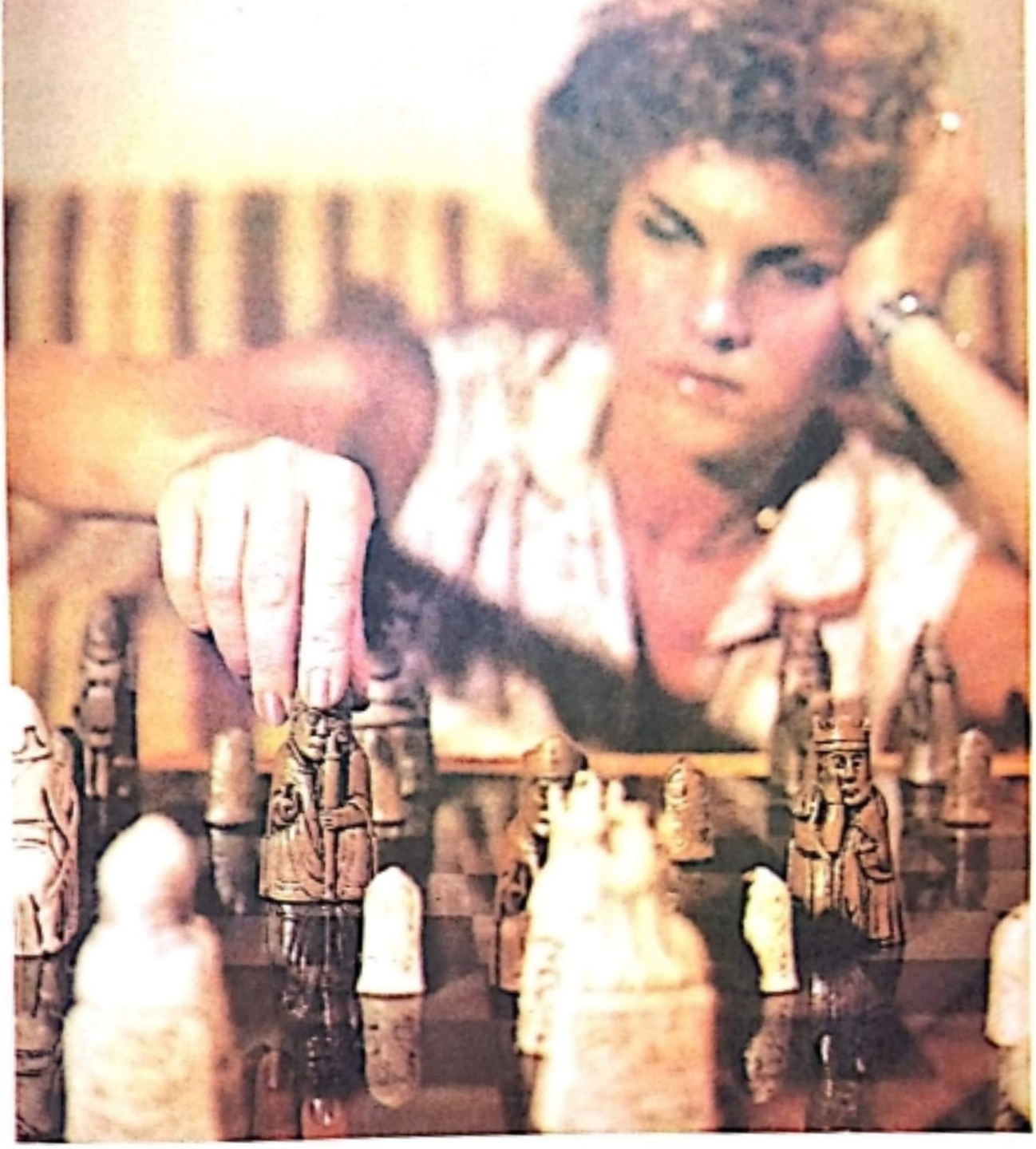
The "nothing" consists of unprotected coitus (to use the technical term). Here, no protection is taken, and one simply trusts to nature and good fortune.

Of course nature is rather provocative. The female's system is geared to the hormonal production rate so that when ovulation occurs, the hormones inside are crying out for sexual satisfaction. So her whole system, feelings, desires, sensations, are geared for intercourse at the very time when conception is most likely to occur. This is the big, big trap with unprotected coitus.

A look at the various "pregnancy rates" of the different methods will give an indication as to how they compare for effectiveness.

The "pregnancy rate" is an index of the efficacy of a contraceptive method. It is

Downloaded from Fountain of Knowledge Library



Your family planning programme must be undertaken with the greatest of care.

calculated as follows. It is the number of pregnancies multiplied by 1200, divided by the number of months of exposure sexually. The higher the figure the less effective the method, and vice versa. The P.R. of the Pill is virtually zero. Here are the figures of other methods.

The intra-uterine device, P.R. 1 to 7

Diaphragm plus spermicidal cream, P.R. 4 to 12.

Spermicidal foam, P.R. 2 to 7.

Condom (sheath), P.R. 6 to 16.

"Rhythm" (or "ovulation method"), P.R. 14 to 35. This figure varies enormously in investigations. Those successfully using the ovulation method will claim these figures are wrong. Great motivation on every occasion and following the rules exactly is imperative for success. The figures for the ovulation method will be better than for rhythm.

For unprotected coitus the P.R. is a disastrous 60 to 80.

Future Prospects

So there are the methods currently available. The future holds some exciting prospects. There is talk of an "immunising injection" being given which will give long-term contraception. In

Downloaded from Fountain of Knowledge Library

some countries a drug called medroxyprogesterone is available as a once-every-three-months shot. It is still being assessed, for its safety has not yet been proven as a contraceptive measure. A variety of new ideas will filter through. It is inevitable, and is merely a matter of time.

For women and men who desire to secure permanent sterility, other methods are available at present. These are called sterilisation, and confer permanent infertility. Ideally they are for couples who have reproduced their full family, and desire no more as a permanent undertaking. Although in rare instances they have been reversed by micro-surgery, for most practical purposes they should be considered to be permanent.

In women, the operation is to permanently ligate (tie) or cut and tie, or seal (often with diathermy) the tubes on each side. This effectively prevents union of the sperm with the ovum, and in this manner pregnancy is prevented.

The Laporoscope

With the advent of the laparoscope not long ago, this is now the simplest method. A small incision (about 1 cm in length) is made just beneath the navel. Then the laparoscope, a long tube with lights and special lenses at the far end, is inserted. This gives an excellent view of the pelvic cavity. The organs of reproduction are clearly visible.

Through another small incision, measuring about 0.5 cm near where an appendix operation incision is normally made, another device is inserted. This contains a hook with which the tube can be grasped. At the right moment, a special current is passed into the hook, and the tube is sealed off permanently with diathermy. The tube is then cut and each end becomes sealed as a permanent measure. Each incision requires about one suture.

Hospitalisation is about one to two days, and the person can return to normal activities within a few days. It is an excellent method, and the results are invariably successful. It has largely replaced the major operation which involved a larger surgical incision, allowing the surgeon access to the pelvic cavity in which each tube was physically cut and tied. The results are identical with the former method, which is now largely taking over with most gynaecologists. Variations of the method are used by some others, referred to as a culdoscopy, in which a similar operation is carried out via the upper vaginal walls.

Although the success rate with laparoscopic diathermy is very high, many women experience complications a few years later, mainly heavy menstrual bleeding. As a result, many doctors now use metal clips to close the tubes, placing two on each tube. At present these seem to be more popular than the diathermy method. It is done with the laparoscope.

Vasectomy

In males, an operation known as vasectomy is available, and has become popular in recent times. It involves cutting and ligating the vas, the tube that conveys the male seminal cells from the testes in the scrotum where they are manufactured. This operation, too, is successful, but it should be regarded as being permanent.

Both of these operations are straightforward. However, in some there are psychological side-effects, largely related to the mental problem that pregnancy thereafter is impossible, and this can adversely affect some men and women. Before the operation is done, a very full appreciation of all the factors, both for and against, must be clearly considered. Many younger women who have had this done in their twenties regret it later on. Particularly is this likely if children or partner are killed or die, or if separations or divorces occur and a new partner enters the scene, and they wish to procreate again. Many situations such as this are on record, so that careful appraisal is imperative.

It should be clearly pointed out that these operations are intended for permanency. As it so happens, up to 5 per cent of women want to have the operation reversed within a few years of it being carried out! Sometimes this is possible, but often the results are unsuccessful, even with the skillful use of modern microsurgery. So, think well before you make the decision and opt for surgical sterility. Certain operations are more readily reversed, but the main objective is permanency. Please keep this well in mind!

In considering any form of contraception, whether it be for temporary, long-term or permanent reasons, it is worth discussing it all very fully with your family doctor or gynaecologist. It goes without saying that there must be complete unity within the family circle about whatever practices and methods are decided upon.

Downloaded from Fountain of Knowledge Library

Chapter Eight:

Why Marriages Fail

At least 30,000 couples are divorced annually in Australia, and the figure is rising. Why are there so many marriage failures? Can they be checked? Are there tell-tale symptoms which indicate trouble is brewing? Many marriage unions could be saved. Once signs of a rift are in evidence, sensible couples could do much to heal the breach and save their future.

In 1982 in Australia the appalling number of 44,088 marriages fell apart. Each year about 115,000 new marriages take place. This sadly means that around one in three fails to survive, and each year the picture is becoming depressingly worse. With relatively recent alterations in the divorce laws, in which divorce seems easier than ever before to secure, it seems inevitable that the figures will start to rise still higher.

How come so many persons, who are prepared to accept the responsibilities of marriage one day, exchange vows and pledge all sorts of things, suddenly change, and wish to opt out? There must be some underlying reasons.

What is even more important, how can a couple, in the early stages of marriage, make sure that they will stay blissfully wedded until "death us do part"? Is there any sure-fire way to success in the marriage game? Are there any obvious lessons that can be learned to avoid heading in this direction? If so, what are they? What advice can be gleaned from couples that have split up?

I have seen countless couples over the years as they have come into my surgery. I've watched little children grow up, and marry. I have watched with considerable interest to see what happens to them, how they make out, how they develop their future.

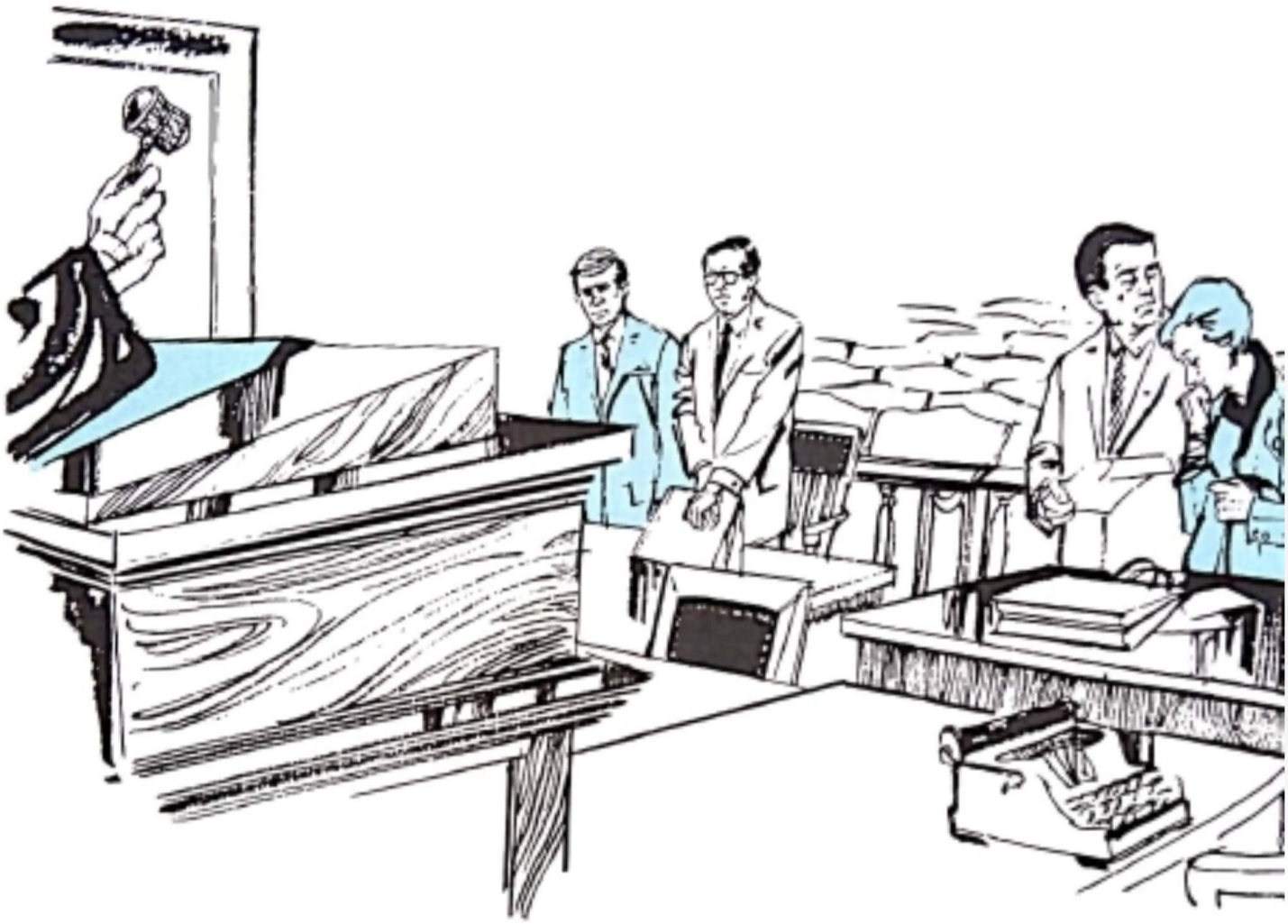
It is fascinating to see the success that many couples make of their lives. It is disappointing to see the abject mess that others (frequently those who should know better) make of their lives.

Certain features seem to leap out, and over a number of years, I am certain that many reasons can be given as to why marriages disintegrate.

There is one feature that has struck me forcibly as I have observed, and each year it strikes me afresh: The way a child develops over a period of years is very often a replica of the way his parents live!

If a person is brought up by parents who have relatively well-set-out and strict moral codes, then the child will absorb these principles, and have similar ones. Indeed, it seems axiomatic that these are impressed upon his sensitive subconscious mind from a very early age. They take root, they are nurtured, they grow and develop, often without the child having any idea

Downloaded from Fountain of Knowledge Library



of what is happening to him or his mind.

The ideals and impressions and standards of the parents become an integral part of the child. As time goes by, he will automatically accept all this, and in time will start to live the life that is being guided by his own subconscious.

When I refer to moral codes, I do not merely mean sexually orientated ones. I refer to the entire gamut of morality. To honesty in general, to one's attitude to his fellow man, to his work-mates, his employers—to those with whom he comes in contact. If a person has been brought up in a home where love and affection abound, then he will tend to reflect these attitudes to others.

Conversely, if the upbringing has been a tight-lipped, austere, mean, hard, poker-faced affair, then this will tend to be the attitude he (or she) will adopt in later life too. Of course, other factors will have their influence too, but in general, the majority will tend to emulate their parents. These things I observe with amazing regularity.

Divorce Creates Divorce

Now let's push the situation a little further. I have also noted that people who subsequently are divorced are those who come from homes where disharmony and dissension have been a regular feature. Often the parents were divorced, this occurring, usually, during the child's early life. Thereafter the child has been brought up listening to an incessant tirade of angry accusations made about the other partner. No doubt, as a small child he heard rows and arguments occurring time and again. When the breakup finally came, there was the inevitable continuation of talk about "that terrible man," "your cruel, horrible father," and so on.

With this mass of negative data in the subconscious mind, there is little doubt that a subconscious negative attitude to marriage must result. And it takes a minor miracle to change that attitude; often it remains to spoil a life for its entire course. Can the importance of providing the child with a secure and warmly affectionate home environment be overemphasised?

Downloaded from Fountain of Knowledge Library

Having said that, let me restate my point in these words: Divorced parents tend to produce children who in due course are more likely to become divorced also.

The Part Sexual Incompatibility Plays

The next big, big factor I have found is that sexual incompatibility plays a major part. No doubt, this is a flow-on, in many cases, from the point mentioned above. Many youngsters fly into marriage completely unequipped. They have given it scant thought, and sexually have often had either lots of single-encounter experiences, or a "steady." Very often premarital sexual relationships have flourished, and these often lead to marriage. However, many find that what was once an exciting experience outside the marital bond, loses its exhilaration in marriage. So, instead of the intimate part of marriage continuing to be an exciting pleasure it tends to become a dreary, dull, monotonous incident, devoid of any "kick," and affording little pleasure.

Very often pregnancy occurs early in the piece. Although the Pill and other forms of birth control are available for the asking in these enlightened days, many women still don't bother or can't make the effort to take regular precautions. Thus, with sexual excursions more frequent in the early days of marriage, pregnancy is a likely result.

With a baby on the way, a common situation is that the young father-to-be often rebels against the state of his domestic affairs. Soon he may seek female company and sexual gratification elsewhere. It doesn't take very long for the birds to come home to roost. Feeling unwanted, the wife starts to complain, and often rightly so. Instead of gaining support and help from her husband, she is frustrated by the unsatisfactory situation, while he is seeking his pleasures elsewhere.

From Bad to Worse

So, a situation once started, rapidly goes from bad to worse. Many women, during pregnancy, or even many who are taking contraceptive measures such as the contraceptive pill feel less inclined to participate in the intimate side of marriage, and the sex act becomes either a chore or entirely devoid of satisfaction. Instead of seeing the doctor and doing something about it (and it is quite possible to get help in the form of medication these days), they grumble, feel sorry for themselves, and hate their partners all the more. Thus the marital situation deteriorates.

Psychologically, hate readily breeds hate. It can smoulder on silently, but may flare up often. Inevitably, matters become worse and worse. Fights develop. Dissension, lack of feeling, lack of consideration for each other, bring about the inevitable breach.

When sex does occur, it is often solely for male gratification. The more this occurs, the less the wife enjoys it. Often it may make her feel off-colour or quite ill. It may even hurt. With little emotional interest, this can reflexly aggravate the condition. If pregnancy is present, this may make it even worse. Aware that the domestic situation is in a bad way, the husband often feels aggrieved, and will go out of his way to find satisfaction in other sources. It may be sexually, but often he resorts to alcoholic excesses in an attempt to make him feel a real man (in his own eyes and those of his acquaintances). If he only knew, it invariably makes him look more of an idiot than a man.

All this does little to help the domestic front. Arriving home often late, dishevelled, and frequently devoid of a good part of his weekly pay packet (alcohol is not cheap, and poker machines and cigarettes are expensive luxuries at present also), he is not very welcome. There is a cold shoulder, an empty fridge, and a disgruntled spouse who is in no mood for fulfilling his sexual desires (demands?), or even giving him a kindly word.

More fights inevitably result. The situation often stumbles on, going from bad to worse. Sometimes the addition of a new baby will temporarily ease the problems, but almost invariably the couple will get off on the wrong track again.

Money Problems

As a rule, money problems come into the picture sooner or later too. When the wife worked, and had her own income, it was not so bad. But with an infant, this becomes impossible. It costs more to live, and often the wife has the task of making the money go round. At such times, many men insist on taking over the financial management of the home. This is likely to lead to more squabbles, more fights, more dissension, more hatred.

The sex picture deteriorates further. No longer does his wife want anything to do with "him." Civil words are few and far between. Fights are common.

Finally, just as the parents ten to twenty years ago split up, so the now generation team is headed in the same direction.

Downloaded from Fountain of Knowledge Library

The two head for the divorce courts. If there are children involved, the picture is so much sadder, for they unwittingly, and without asking for it, become caught in the web. Once more history is about to repeat itself. The children hear and see what is occurring. Just as their parents are similarly ensnared, so their subconscious minds are absorbing all the unhappy, unfortunate incidents, preparing them, in all probability, for a similar fate in twenty years' time.

So, another marriage becomes a statistic, to be looked at and clucked over by social workers and ministers and any others who might have done something but never did.

Some Seek Counsel

Some make an effort, and see their minister, doctor, social worker, or marriage guidance counsellor. But in the main, these are the minority. The one who is trying to hold the marriage together, "for the sake of the kids," is usually the one to seek help. (I've heard that overworked phrase "for the sake of the kids" quoted a thousand times over during the years.)

So where does that leave today's happily married couple on the brink on a brand-new life?

Several critical features stand out, and I'll list them briefly.

First: If you come from a divorced family, then the odds are stacked against you. But this does not mean inevitable failure. It simply means that to succeed in marriage yourself, you will have to make an extra-determined effort to overcome the problems that will beset you. Be prepared to work hard at your marriage. Be prepared to overlook the little things, the possible irritations, the unimportant features which are really of little concern to the total pattern of life.

Second: Make certain that you are totally aware of the importance of the sexual side of marriage. If you think you know everything, you're probably headed for disaster. Read books, read magazines, get information on what is the role of each partner. And think of your partner, not yourself. Try to incorporate some of the thoughts and suggestions outlined in the relevant section of this book—or some other authoritative book on sex technique.

Let me make it very clear. In nearly every case of divorce, sex almost always looms as one of the major factors. It is often not mentioned, but when it comes to the basics, it often features boldly. Never underestimate the importance of sex in marriage. If you fail here, then the chances of success start to wane dramatically. I have seen too many broken marriages over too many years to believe otherwise.

Basic Advice

Third: If people remembered the simple advice given in the "golden rule," there would be fewer divorces. "Do unto others as you would like them to do to you." It is simple. It is also basic.

If this routine were followed through, I am sure the divorce rate of this country would drop significantly in the first year. In all respects, give your partner your first consideration. Put yourself in your partner's position, and try to see yourself through his or her eyes. It will dramatically alter your entire outlook.

Fourth: The love of money is the root of all evil, the Bible says. This is a significant point. It is essential to come to a satisfactory understanding regarding the family finances early in marriage. This will do much to allay any anxieties, tensions, arguments and misunderstandings later on. Money is essential in this world; it is also the cause of considerable argument and discontent. So, make certain that soon after your family unit is established you come to agreement and satisfactory arrangements regarding this. It is vital.

Fifth: Attention to most of the other general matters mentioned in this section of this book is also important. You must have a workable understanding about your in-laws; about your friends; about your likes and dislikes about entertainment; your attitudes about religion. The more you have universal compatibility on these matters, the less likely it is that fights and rifts will occur.

Sixth: Work at your marriage, right from the start, even if you are working from a poor start. Hard work can do miracles in any marriage—especially if both of you work at it!

Downloaded from Fountain of Knowledge Library

SECTION 2:

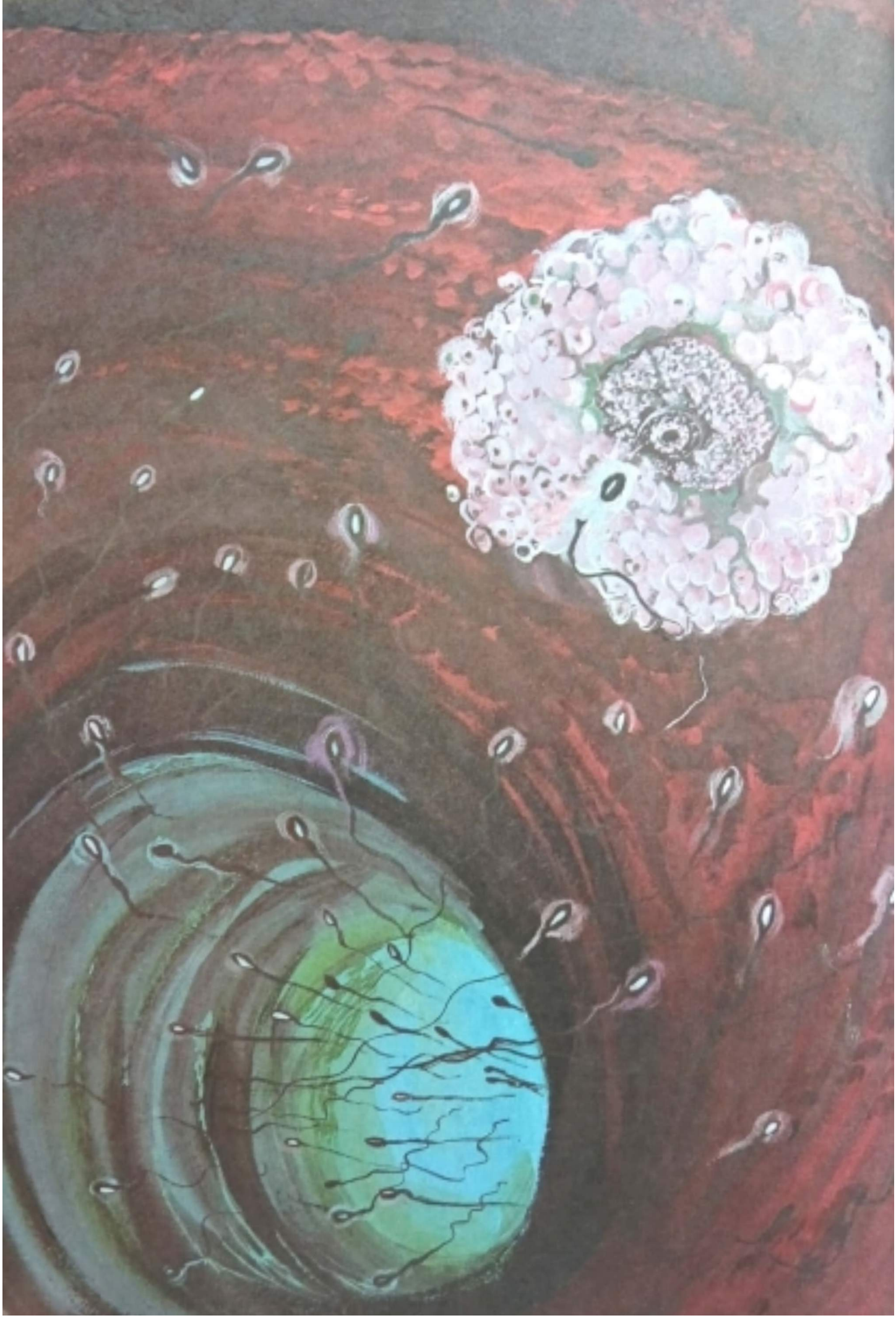
pregnancy and reproduction

This section is designed to help pregnant women and mothers-to-be all over the world. We start at the moment of conception, and describe the story in easy-to-follow detail, until the climactic event, "Baby Arrives!" Complete advice on procedures, care and attention to health throughout is clearly outlined. Profusely illustrated.

CHAPTER HEADINGS:

1. How Do I Know I Am Pregnant? 65
2. Adequate Medical Care Is Essential 70
3. The Practical Benefits of Correct Thinking 79
4. Sensible Care Pays Off 83
5. There Are Certain Risks. Beware! 88
6. Watch Your Weight When You Are Pregnant 95
7. Sensible Eating Pays Off 98
8. Annoying Problems that Occur During Pregnancy 101
9. Things That Can Go Wrong and How They Are Corrected 107
10. Termination of Pregnancy 115
11. The Exciting Happenings of Pregnancy 120
12. Baby Arrives! 131

Downloaded from Fountain of Knowledge Library



Downloaded from Fountain of Knowledge Library

Chapter One:

How Do I Know I Am Pregnant?

Certain well-known characteristic signs may indicate pregnancy. But today, modern immunological tests remove the guesswork.

So you think you may be pregnant?

Congratulations!

If you are correct, then exciting times lie ahead. Indeed, it is highly likely that the most interesting and physically and mentally rewarding part of your life is about to start.

Becoming pregnant and giving birth to a child is the climactic point in the life of every woman. Your whole system has been gearing up for this momentous event right from the day you were born.

If this represents your very first pregnancy, then the future is even more exciting. Suddenly you find you're a member of the "in" group. Your friends accept you with a different attitude. You are about to achieve something. You have made the grade, so to speak.

This is the ultimate in feminity. Nothing is more "female" than fulfilling the role for which you have been designed by nature. Parts of the body that have simply remained dormant for all these years jump into life. Activity abounds. You are the centre of all this quietly occurring hustle and bustle.

A Series of Changes

Gradually a series of physical changes take place. Each one is brimful of interest. As you witness your system getting with the action, there is a stimulating and rewarding mental attitude that instils a warmth unobtainable in any other way.

The mental image of producing a brand-new life, basically the replica of "you," is an ego-boosting event that can only yield happiness, a sense of achievement and a sense of fulfilment.

Sometimes the idea comes as a shock at first. In today's world, where methods of family planning and birth control are readily available to everyone, some women are not prepared for the sudden news that they have become pregnant. Others merely hope it won't happen to them, until they are more economically and financially secure—until the house is paid off; until the furniture has been bought; until they've had a world tour, and so on.

Still others are having domestic problems, such as living with in-laws or relatives. Or there may be razor-edge problems between husband and wife, with tempers and emotions flaring. Marital rifts may be imminent; these are common, and seem to be increasing in frequency these days—especially in the first two years of marriage.

But despite all these factors, when the idea of another member suddenly appearing on the

Downloaded from Fountain of Knowledge Library

scene might seem disastrous, the event can often be a catalyst that brings a husband and wife closely together once more.

Most babies are wanted right from the moment of conception but unfortunately, some are not. However, with the progression of time, it is very rare indeed not to see a deep attachment form—especially between mother and baby—as the pregnancy develops. By the time the newcomer makes his lusty entry into the world, he is usually wanted and accepted with the most sincere devotion and parental love.

Father Becomes Involved

These modern days there is a tendency for the father to become more involved in the entire proceedings. This is a good thing, and more and more doctors actively encourage "father participation."

This encourages the idea of sharing, of making the male parent feel that he is more than just an onlooker, and the person who is around to pay the bills. Involvement pays off. It brings both prospective parents into closer unity right throughout the happy months of the pregnancy.

Many hospitals and many obstetricians actively encourage the father to be present at the actual moment of the birth. In this way, he shares in a very real way the full mental and physical aspects of this wonderful event. He becomes part of the scene, and frequently lives every moment of the experience with his wife. Sharing the momentous event inevitably yields a warmth and humanity that can occur in no other way, and once involvement of this nature occurs, it is likely to continue for years to come. This of course, spells success from a very early date.

However, even though the idea of togetherness is an excellent one, and is used by many modern hospitals and obstetricians, do not be upset if your own doctor does not approve. Every doctor has his own ideas. These are generally moulded over a number of years, and he will set out quite clearly what he prefers, and what he feels is in your own interest. Some hospitals are not physically geared to have extra people around when they are not actively engaged in the working routine. But if the opportunity is given for father to be present at the birth, give the matter some thought; it is the experience of a lifetime.

Of course, there are many males around who are very strong and physically masculine—that is, until it comes to the sight of blood, and things like injections. Then, many of the bravest and most stout-hearted suddenly find their knees turn to water!

It is no joke, but a fact of life, and nothing to be ashamed of. But on numerous occasions, tough he-men have been known to faint dead away on the delivery-room floor when the going became rough, or the patient required an injection, or they caught a sudden sight of blood.

So, be guided by the advice your own doctor gives you both at the time. He is most likely to know both of you well, and from his experience, he will offer the most suitable recommendations, tailor-made just for the two of you.

How Can I Be Sure?

A big question that looms large in the mind of a woman is the query: "Am I really pregnant? How can I be sure?"

In many cases, the situation is fairly obvious from the start. But in others, it is quite obscure. Of course, one thing is certain: time will yield the answer in every case. But nearly every woman has a burning desire to know with some accuracy if she is or is not pregnant, if there is any such possibility.

The first sign is usually a missed period in a woman who normally menstruates regularly, and who is not following any contraceptive routine while engaging in normal marital relations with her husband.

A few lucky women seem to commence their menstrual bleeds with amazing regularity. Indeed, "I can set my clock by it all," some claim. At a given hour on a given day each twenty-eight days, menstruation sets in. So, if this suddenly did not occur, it is excellent presumptive evidence that conception has taken place.

However, most women are not built with such mechanical precision. Just the same, menstrual regularity within a day or two each month can still produce similar presumptive suggestion of conception.

The normal menstrual cycle has very wide variations. Although many women average a twenty-eight-day cycle, the range may swing from twenty days up to forty days or even more. Indeed, some women go as long as forty-five days, and occasionally, some manage two or three periods a year!

It is with these women that accuracy in pinpointing pregnancy is a little more difficult. But there are many other pointers to pregnancy, so that one individual sign, although it may be very important in some women, is not the criterion by any means.

However, with the "regular" ones, the

Downloaded from Fountain of Knowledge Library

missed period is often the first obvious sign, and the one that sends the majority scuttling off to their doctor post haste. Many doctors likewise consider that a missed period in a normally menstruating woman is to be considered due to pregnancy until proved otherwise.

Woman's Intuition

There are some women who seem to have an inbuilt intuition that is unexplainable. They simply *know* that pregnancy has taken place.

They have a "feeling" or a "hunch" or whatever. "I just feel pregnant," is frequently their total explanation of the situation. "I feel different, that's all." Most physicians accept this, and go along with the feminine instinct which usually proves to be correct! After all, you can't argue convincingly with a determined female when her mind is made up, the doctor probably says to himself. But added to this is his own professional experience of dealing with hundreds of women over many years. He knows natural instinct is often correct. Maybe it is one of those interesting whims of nature, and after all, the world is full of these in various avenues of life.

However, there are quite a few other indications that pregnancy has taken place, chief among them being:

Nausea and Vomiting. This is the so-called "morning sickness" of pregnancy. Nobody is quite sure why it is called "morning" sickness, for it can occur at any time over the twenty-four-hour cycle of the day. It is common in the morning, but it is frequently at midday and towards evening.

In fact, this takes place in well over 50 per cent of women between the fourth and ninth week after the last menstrual period. Fortunately, more feel nauseated than those who actually vomit. In only a small number does it become a serious, disabling symptom. But added to other symptoms, it can often be of valuable assistance in confirming a diagnosis. (We shall tell how this may be effectively treated later on.)

Frequency of Urination. The woman usually notices a marked increase in the desire to pass urine. The amounts passed may only be small. There is usually none of the burning or discomfort that takes place with bladder and urinary tract infections. It is due to the physiological changes occurring in the pelvic area, and is quite a normal event. But, it also helps the physician to form a diagnosis of your pregnant state accurately. It is a good indication to you too, before you make that initial visit to the doctor.

Breast Changes. Changes that occur in the breast itself constitute a fairly early sign. Very early in pregnancy, increasing amounts of chemicals called hormones are produced by the ovary and womb. These actively circulate to all parts of the system. Basically they help to prepare the womb in particular, but also the body in general for the impending event.

The breasts play a major part in pregnancy, and these are geared to become active so that a natural, normal food supply will be readily available for the new infant immediately he makes his debut into the world.

So, the hormones start acting on breast tissue right from the start. The breasts tend to become enlarged. The nipples likewise enlarge, becoming more prominent, and often quite tender. The areola, the pigmented area surrounding the nipple, darkens. In women who have never before been pregnant, the normal, natural pinkish colour gradually changes to a darker shade, and finally becomes a dark brown. Once it assumes this darker colour, it remains this way for the remainder of one's life.

Effect of the Pill

One point of interest is that in women who take the contraceptive pill, this pigmentation will occur while they are on the Pill. The reason is that the Pill contains hormones similar in nature to those produced during early pregnancy. Their effect on the breast is very similar. Not only will it turn the areola a darker shade, but often it will produce an artificial enlargement of the breast itself.

In fact, many younger women with poor chest development elect to take the Pill exclusively for this reason. Of course, this is not recommended. The sad truth is that as soon as such women cease taking the Pill for any reason, the breasts tend to regress to their original smaller size. Or, as many have discovered to their sorrow, they may diminish even more than in the pre-Pill-taking days. So, any woman reading this and contemplating getting onto the Pill for these reasons should think again. It is not a very good idea for purely cosmetic reasons!

Besides the areola becoming darker and the nipples more prominent, small raised areas occur in the pigmented parts. These are due to little glands that are excited by the hormones, and they become quite prominent. They appear as little raised pimples.

Downloaded from Fountain of Knowledge Library

This is not serious and it is not dangerous, and they should not be squeezed or fiddled with. They are not like acne blackheads on the face, that are common with some women.

Often as the breast enlarges, veins become a prominent feature. These appear as bluish lines coursing all over the breasts. They are frequently more prominent about the nipple and areola area. This merely indicates that breast activity is occurring. Everything is being geared to the ultimate nutritional care and well-being of the forthcoming infant. Nature is very aware of what the future holds, and makes every effort to be prepared.

Temperature Increase. A fairly valuable sign that is readily available, but not used very much, is the basal temperature sign.

It is well known that the body temperature rises at the time ovulation occurs. This is the moment the tiny egg is released from the ovary. It occurs approximately fourteen days before the expected onset of a subsequent menstrual period. In women with a normal twenty-eight-day cycle, this also means ovulation occurs about fourteen days from the start of a period.

This sign is often used in women being investigated for the inability to fall pregnant (a condition technically referred to as "infertility.") This will be dealt with later on.

At the time of ovulation, the temperature rises, perhaps as much as one degree. This generally falls again after a couple of days. But in the pregnant woman, the rise is sustained.

About this time, most women will have decided to go along to the doctor to discover for sure if pregnancy is under way. Many will have a good idea that conception has occurred, but most women are much happier to have this officially confirmed.

The doctor has a few other ways of checking. First of all, he will listen to your story. Generally he will take notes on a history card, ask a lot of related questions and enter the answers on the card. After this, he will then carry out a physical examination. At the first visit, this may be a complete physical examination, or he may wait until a subsequent visit before he does this in detail.

But he will almost certainly carry out a pelvic examination.

This is simple and quite straightforward. His aim is to confirm pregnancy or otherwise, and frequently in addition to the points you have told him, some physical changes may be checked.

Vaginal Changes. He will examine the breasts for the changes already discussed. Then he will examine the vagina and check the uterus (womb).

Physical changes may have occurred in these regions. The vulva, the loose lips guarding the entrance to the vagina, are frequently a dusky bluish discolouration. This often extends up the front wall of the vagina. The vagina and cervix, the part of the womb that juts into the upper part of the vagina, become softer and more discernible. These are due to an increase in the vascularity of these parts, and are usually evident as early as the fourth week.

Uterine Changes. In the early stages, it is sometimes possible to feel certain changes in the uterus. The doctor will check for the firm cervix of the womb. The upper part, containing the embryo, may also be a little more firm, but the middle part of the womb is softer. However, in plump women this is often very difficult to be certain about, and many doctors feel it is not possible to make a firm decision on "palpation" (as this technique of feeling is called) until many more weeks have elapsed. However, in some instances it may be useful.

Pregnancy Tests. With the advent a few years ago of reliable tests collectively referred to as "immuno-chemical tests," it is now possible to obtain quick and accurate results. In fact, by using some forms of the test, an answer can be forthcoming in a matter of minutes!

Those that can be read after two minutes are claimed to be 92 per cent reliable. A similar test which occupies about two hours is said to be about 98 per cent accurate. These degrees of accuracy are very high. When teamed in with the patient's history, the symptoms she describes and the results of the physician's physical examination, it usually leaves very little doubt in anybody's mind whether conception has or has not taken place.

Certain precautions are needed when carrying out the pregnancy tests. Ideally, it is a "first" specimen of urine taken during the initial act of urination for the day. The bottle should be clean and free from contamination by drugs or chemicals. (This could possibly give a false reading.) If there is any time-lapse between the time the urine is passed and the time of examination (and a few hours is most likely), the specimen should be refrigerated.

The doctor is seeking to prove the existence in the specimen of urine of a specific hormone called "H.C.G." This is short for Human

Downloaded from Fountain of Knowledge Library

Chorionic Gonadotrophin. It is produced by the developing embryo, and actively circulates in the bloodstream. A certain amount is excreted in the urine. If it can be picked up by the use of the test, it is an almost certain guarantee of pregnancy.

However, it takes almost six weeks from the date of the last menstrual period for adequate amounts to be excreted in the urine. Therefore, if the test is carried out before the six-week period, it will most likely yield a negative result, even though the person may be pregnant.

A popular routine is to carry out the H.C.G. test at six weeks. If it indicates negative, and the patient shows many of the other signs of pregnancy, the test is carried out again seven to ten days after. A positive result is then probable, indicating pregnancy has actually occurred.

The doctor will most likely check to see what forms of medication (if any) you are taking. Certain drugs, it seems, can produce incorrect results with the immunochemical test.

The introduction of the simple and accurate immunological pregnancy tests has been a major step forward in the early accurate disgnosis of pregnancy.

New Blood Test for Pregnancy

Since the original urine test for pregnancy was worked out, a quicker and even more reliable one has been developed, and this is now widely used by doctors. In fact, pregnancy can accurately be diagnosed within twenty-four to thirty-six hours of conception. One does not even have to miss a period. It is called the radio immuno assay pregnancy test, or R.I.A. Pregnancy Test for short. Taking a blood sample, a special machine can detect extremely minute traces of H.C.G. circulating in the mother's blood. It is far more delicate and accurate than the H.C.G. urine tests, and will undoubtedly replace it in due course.

Frogs and Toads Are Out

In years past, reliance was placed on other methods, which were time-consuming and extremely clumsy, to say the least. Prior to their introduction, tests involving toads, frogs and rats were the only methods available. This involved injecting these creatures, then killing them, carrying out an operation several days later and examining the pelvic organs. It was a major problem keeping masses of livestock, and one which pathological laboratories disliked immensely. But now all that is changed, and often an accurate check can be done while you are still at the doctor's office. Times have changed, methods have taken a marked forward step, and the person to reap the benefit, is you.

So, it does not take too long for you to have a firm diagnosis as to your pregnant state or otherwise.

One point is worth emphasising. Once you suspect you are pregnant, or if you have even a few of the tell-tale signs, make an appointment to see the doctor.

It is now very well recognised that the entire undertaking of pregnancy, from conception to delivery, is a very important event.

Supervision, Not Luck

Trusting to luck, and hoping that everything will work out all right is an idea that belongs to the Dark Ages. This is not the modern concept. There has been a vast increase in knowledge in relation to pregnancy and the production of babies. It is becoming more and more a technical skill that needs expert supervision.

The dramatic reduction in maternal and infant deaths in relation to pregnancy is proof positive that the skills now universally available to women are paying off.

So, get along to your family doctor if you believe you may be pregnant. If you are incorrect, that doesn't matter. If you are pregnant, then the sooner a start is made on proper prenatal care, the better. At least a diagnosis may be made, and you can jump on the band-wagon of sensible antenatal attention that is so vital today.

It is in your own interests. But more important, it is also in the best interests of your internal passenger, your unborn baby. It is up to you to do your best for him. He cannot make you do the right things. It is entirely in your own hands. Do not let him down.

Downloaded from Fountain of Knowledge Library

Chapter Two:

Adequate Medical Care Is Essential

Skilled medical care from the moment you conceive is today's concept of modern obstetrics. This leaves nothing to chance. "Good luck" and the bad old days are the legend of a bygone era. They are not for today's modern mother-to-be. Only the best will do.

So you have become pregnant!

The tell-tale symptoms were right. You thought you were, but now this has been officially proved. Tests with a high degree of reliability have indicated that you are. You feel pregnant. What's more, you probably have started to get the pregnant look about you. Some deny that this happens, but others believe it to be true.

As time goes by, the look becomes more and more of a reality. Indeed, not only will the inner you tell you that you are very much pregnant, but the mirror will confirm the news without a doubt.

Soon your friends will begin asking questions. That is, if you don't tell them first, and it is a good idea to share the news around. The psychological value to be gained from the kind words and interest of your close friends and relatives at this time is often very supportive. Indeed, it can make the whole undertaking seem that much more intimate and real, and an occasion for inner rejoicing.

Parents are usually a great help when they learn that you are pregnant. Comforting, encouraging words are always welcome in this hard, cold world, and when spoken by kindly parents, they are all the more encouraging and appreciated.

Parents have been through the business before, perhaps on several occasions. They know what is involved. It is often worth taking notice of what they have to say, for experience is a wonderful teacher. Of course, you will learn a great deal for yourself, but very often, in sudden time of need, a few words of advice or caution, spoken by a senior, will be recalled. It can be helpful, and very encouraging.

Advice and "Advice"

However, even in these enlightened days, there is advice and there is "advice." Good advice can often provide a sound, helpful backdrop for future events, but there is a surprising number of people who seem to recall only the negative side of parenthood. Maybe it is a reflection of their own personalities or of their own personality defects, inner inhibitions and anxieties. But some older women seem to delight in offering "advice" that is not worth having.

They seem to delight in going over the unhappy incidents of their own past adversities in minutest detail. They will describe with intimate detail the pain, the suffering and the

Downloaded from Fountain of Knowledge Library

agony of their own confinements. They will take great delight in downgrading the doctor, the hospital, the nursing staff, the food, the circumstances. Nothing, it seems, went right. So they will tell and retell to any available ear, of the unhappy event that constituted their obstetric past.

Turn a deaf ear to these Job's comforters. A closer check will often pinpoint the true source of the problem. It was not the medical attendants, or the unsatisfactory hospital conditions, or the lack of attention in many cases, but their own strange approach to life. Many expected trouble from the start. Maybe they had been adversely programmed by some foolish woman early in their pregnancy, and looked for things to go wrong. In this world, "Seek and you shall find." This often means bad things as well as good things! Never forget it.

So, try to avoid the troublemakers, and those who seem to find a fiendish glee in unnerving you and throwing unhappiness your way in the guise of offering "sound advice." Turn away, and steer clear of these Jeremiahs (male and female) from that point forward.

If you have questions, the best idea is to make a note of these day by day. Then, when you attend your doctor for your regular prenatal checks, take the list along with you. Check them off with him one by one. He will give you an honest, experienced, straightforward answer. This is by far the best way of gaining accurate answers to any question you may have in your mind. This applies to any part of your forthcoming confinement or the events occurring during your pregnancy.

So, summing up. Share your happiness with your close friends and those you feel you can trust. Enjoy their encouragement and approval. But go easy on the potential troublemakers. Lastly, stick with the doctor and his advice in most matters.

There are lots of factors that you will need to know. There are certain matters on which you must make a decision. Many of these must be done in consultation with somebody else. But here are some of the chief features that will exercise your mind from an early start.

CHOICE OF DOCTOR

From the moment you believe you may be pregnant, it becomes necessary to decide on a visit to the doctor. This immediately raises certain questions. The decision you make will depend to a large extent on where you live, in the city or the country, or in what land, such as Australia, America, England or some other country. Every place has its own set of situations. But generally speaking, you must see a doctor.

Very often, this will be the doctor you attend for your usual small illnesses. He may be a "family doctor" or "general practitioner." Maybe you and the family have been attending him for years past.

It is often convenient to check with him in the first instance, irrespective of what eventuates. He can often do the initial checking, and give you a definite "yes" or "no" answer as to whether you are pregnant or otherwise.

Many family doctors still carry out their own practice of obstetrics. If this is the case, the doctor will forthwith book you into the hospital he attends, and take over the prenatal care from that moment. You will then attend him regularly, at the specified times, and he will finally deliver the baby and care for you while you are in hospital.

Specialist Obstetrician the Ideal

However, more and more family doctors in the Western world are choosing to leave obstetrics to specialists in that field. As more information and practices are involved, the whole matter of obstetrics is tending to fall completely in to the hands of the specialist obstetrician. Many doctors believe this is a good thing, and are glad to see this trend, believing it to be for the greater welfare of the mother and the baby.

In recent years, increasing numbers of new techniques and procedures have become available. Many are very sophisticated, and constant experience is necessary for the doctor to remain facile in these procedures. The more the obstetrician carries these out, the more adept he becomes. Therefore, many doctors feel their patients are much better cared for in the hands of experts such as this.

Obstetricians are usually closely associated with certain hospitals in which they have complete faith. They will usually select a hospital which they know is geared to cope with any emergency that may arise.

There is absolutely no doubt that many small hospitals are ill-equipped to cope with some of the serious complications that can arise suddenly and without warning. This means there is a high risk to the mother and the infant at the time of birth.

Why take risks? It is not worth it. Enough problems lie in store under normal cir-

Downloaded from Fountain of Knowledge Library

cumstances, so "only the best" is the most plausible advice that can be offered.

Listen to Your Family Doctor

So, if your own family doctor suggests a specialist obstetrician, then go along with his advice. He will most likely refer you to an individual specialist in whom he has special confidence. So, if your doctor suggests you see Dr. X, then happily make an appointment to see Dr. X. You will then remain with him for the remainder of the prenatal period. The doctor will deliver your baby, and will care for you while you are in hospital. Finally, he will see you once or twice, or more if necessary, after you have ultimately left hospital and are back home again after confinement is over.

In Australia and New Zealand the medical picture is rapidly changing. It changes from state to state and from month to month. There is much talk of patients attending specialists becoming linked to the hospital they will ultimately attend rather than to a specific specialist. But the basic principle remains the same. Attending a specialist for a confinement is considered the ideal thing in many instances for many women.

In the overall picture, be guided by your own doctor from the first visit, and go along with his recommendations. He will have your interests at heart at all times.

CHOICE OF HOSPITAL

Many women have their hearts set on attending a certain hospital. This is usually because a close relative or friend attended that particular hospital for her confinement. Maybe you visited her there, found everything to your liking, and decided it was the place for you if and when your time came.

Moreover, your friend probably extolled the virtues of the place. She has told you how happy she was there, how efficient the services were, how kind and thoughtful and attentive the nursing staff were, and how delightful and well prepared and served the food was.

These are important factors, to be sure. If the efficiency of the institution extended also to the more practical medical side, if it is geared to meet all possible requirements, to cope with all emergencies and eventualities, then that hospital may indeed be the ideal place for you.

But a few other factors are also worth bearing in mind. If the hospital, no matter how good it is, happens to be located many miles from where you live, and is almost inaccessible, then it may not be the most convenient place after all. Just think that you are actually to live there for about a week (more or less, depending on how you fare). No doubt you will look forward to frequent social visits from your family and friends. If you are situated miles away, the chances of very many visits will not be high. It is not important now, but later on it may be a factor that makes your hospital days happy or not-so-happy. At least, it is worth bearing in mind.

Also, you must physically "get to the hospital on time." Of course, with confinement number one, there is usually plenty of warning time. But with subsequent confinements, there is not always a great deal of time between the initial warnings and the time baby puts in his appearance. So, long distances to travel (maybe in traffic snarls and peak-hour difficulties) could present a problem. You will have enough to cope with at the time without worrying about the mechanics of getting to hospital in safety.

Many a baby has been born in a taxi or an ambulance en route to the hospital. Such events often make the front pages of newspapers. But it is certainly a most undesirable situation, both for mother and baby. Indeed, it can lead to major problems, and is definitely not for you.

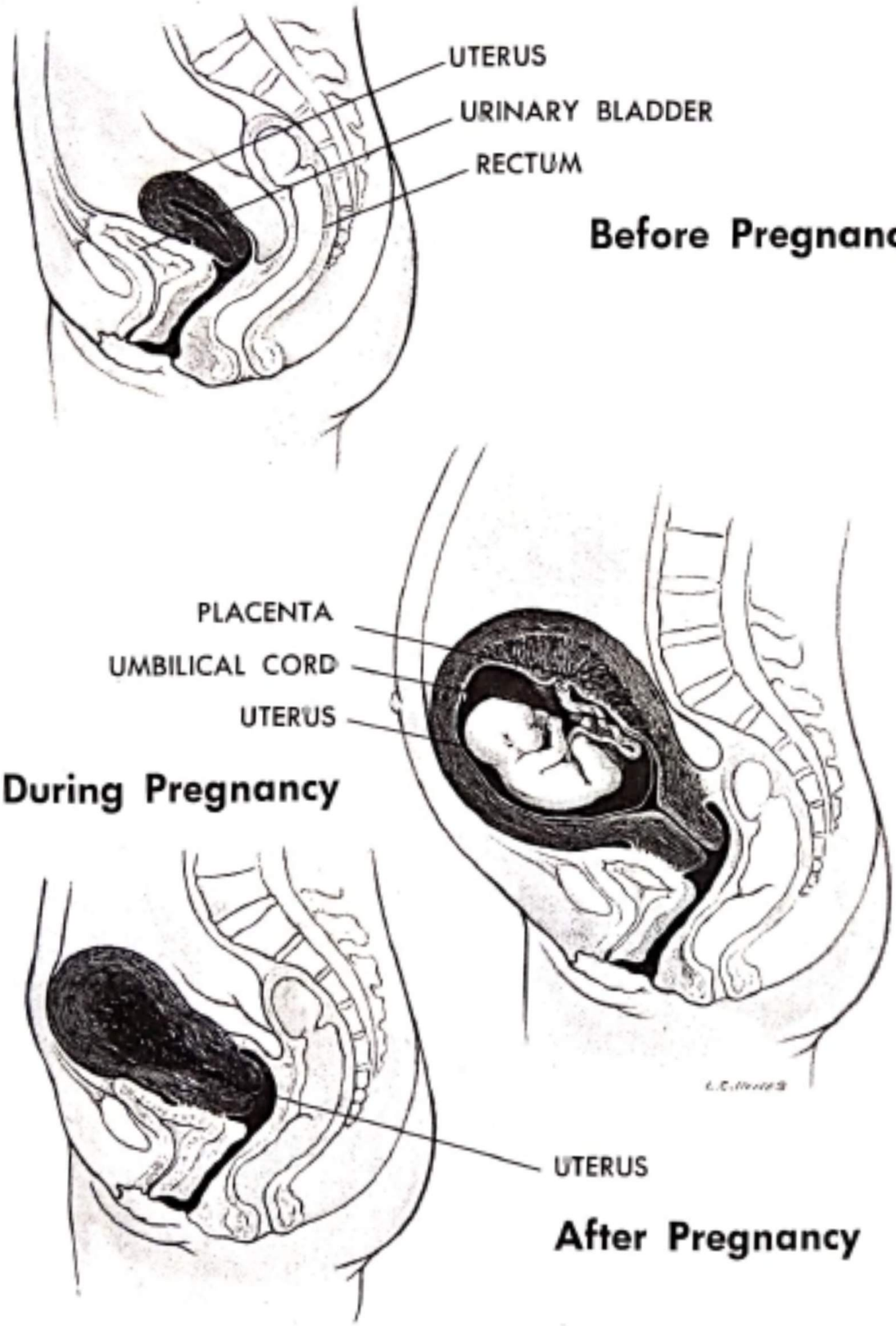
So, when you discuss doctors, the hospital situation must also be considered at the same time. The sooner this is attended to, the better. Usually the doctor arranges the hospital booking. Often it is necessary for you to back this up by a personal attendance at the hospital, fill out certain forms, pay a deposit, and attend to certain formalities. In these days of hospital overcrowding, it is essential that this all be attended to very early. Frequently, the doctor will do his part within minutes of your leaving his office after the initial attendance.

These days, economics often plays a part in medical care. So, some people will prefer to attend hospital clinics direct. Once more, it is a case of taking action promptly as soon as you feel you may be pregnant. Once there, the routine is very similar to the system you will follow if you attend a doctor in a private capacity. In short, you get aboard the merry-go-round, and you go wherever it takes you.

BABY'S ARRIVAL

The question every mother wants answered immediately on confirmation of her pregnancy, is, "When will the baby be born?" This is a sensible query, and the answer can be given promptly. In fact, you can work it out for yourself.

Downloaded from Fountain of Knowledge Library



Downloaded from Fountain of Knowledge Library

There are lots of ways in which this may be done, and they all yield approximately the same answer. The actual duration of pregnancy is 266 days on average. This is the number of days from the moment conception occurs, to the moment the baby is born and becomes a viable, living person quite separate from its mother.

However, for the point of convenience, it is customary to measure dates, not from the time of conception, but from the first day of the last menstrual cycle. This, in a woman with a normal twenty-six- to thirty-two-day cycle, is 280 days. It equals nine calendar months (or ten "lunar" twenty-eight-day months).

The abbreviation L.M.P. is widely used by doctors and hospitals to refer to this important date, and it is the abbreviation for "Last Menstrual Period." From this date, the time of the baby's arrival can be readily calculated. This is referred to as the "E.D.C." This is short for "Estimated Date of Confinement."

To avoid the time-consuming job of sitting down and adding 280 days to the L.M.P., charts have been worked out which clearly indicate this. The top line gives the L.M.P. for each day of the year. Directly underneath is given the E.D.C. corresponding to each date. So, this chart can give the answer in a moment. A table of this nature is included for ready reference.

Another Simple Method

However, many doctors use another simple method. They simply add ten days to the L.M.P. and count back three months. That gives a fairly accurate date, and this is projected ahead.

For example, let's say the L.M.P. was June 10.

June 10 + 10 days = June 20, less three months = March 20.

The E.D.C. will then be March 20 the following year.

It is as simple as that, and it is remarkably accurate. Many doctors use this quick method, and it can be worked out in a matter of moments. In fact, patients are always impressed at the speed at which this date is arrived at, particularly as most have already pre-checked with a table themselves, and find the dates coincide.

There are various other methods of determining the baby's birth date. The "time of

OBSTETRIC TABLE

The calculation is made from the first day of the last menstrual period

January *October*	1 8	2 9	3 10	4 11	5 12	6 13	7 14	8 15	9 16	10 17	11 18	12 19	13 20	14 21	15 22	16 23	17 24	18 25	19 26	20 27	21 28	22 29	23 30	24 31	25 1	26 2	27 3	28 4	29 5	30 6	31 7	January *November*
February *November*	1 8	2 9	3 10	4 11	5 12	6 13	7 14	8 15	9 16	10 17	11 18	12 19	13 20	14 21	15 22	16 23	17 24	18 25	19 26	20 27	21 28	22 29	23 30	24 1	25 2	26 3	27 4	28 5			February *December*
March *December*	1 6	2 7	3 8	4 9	5 10	6 11	7 12	8 13	9 14	10 15	11 16	12 17	13 18	14 19	15 20	16 21	17 22	18 23	19 24	20 25	21 26	22 27	23 28	24 29	25 30	26 31	27 1	28 2	29 3	30 4	31 5	March *January*
April *January*	1 6	2 7	3 8	4 9	5 10	6 11	7 12	8 13	9 14	10 15	11 16	12 17	13 18	14 19	15 20	16 21	17 22	18 23	19 24	20 25	21 26	22 27	23 28	24 29	25 30	26 31	27 1	28 2	29 3	30 4		April *February*
May *February*	1 5	2 6	3 7	4 8	5 9	6 10	7 11	8 12	9 13	10 14	11 15	12 16	13 17	14 18	15 19	16 20	17 21	18 22	19 23	20 24	21 25	22 26	23 27	24 28	25 1	26 2	27 3	28 4	29 5	30 6	31 7	May *March*
June *March*	1 8	2 9	3 10	4 11	5 12	6 13	7 14	8 15	9 16	10 17	11 18	12 19	13 20	14 21	15 22	16 23	17 24	18 25	19 26	20 27	21 28	22 29	23 30	24 31	25 1	26 2	27 3	28 4	29 5	30 6		June *April*
July *April*	1 7	2 8	3 9	4 10	5 11	6 12	7 13	8 14	9 15	10 16	11 17	12 18	13 19	14 20	15 21	16 22	17 23	18 24	19 25	20 26	21 27	22 28	23 29	24 30	25 1	26 2	27 3	28 4	29 5	30 6	31 7	July *May*
August *May*	1 8	2 9	3 10	4 11	5 12	6 13	7 14	8 15	9 16	10 17	11 18	12 19	13 20	14 21	15 22	16 23	17 24	18 25	19 26	20 27	21 28	22 29	23 30	24 31	25 1	26 2	27 3	28 4	29 5	30 6	31 7	August *June*
September *June*	1 8	2 9	3 10	4 11	5 12	6 13	7 14	8 15	9 16	10 17	11 18	12 19	13 20	14 21	15 22	16 23	17 24	18 25	19 26	20 27	21 28	22 29	23 30	24 1	25 2	26 3	27 4	28 5	29 6	30 7		September *July*
October *July*	1 8	2 9	3 10	4 11	5 12	6 13	7 14	8 15	9 16	10 17	11 18	12 19	13 20	14 21	15 22	16 23	17 24	18 25	19 26	20 27	21 28	22 29	23 30	24 31	25 1	26 2	27 3	28 4	29 5	30 6	31 7	October *August*
November *August*	1 8	2 9	3 10	4 11	5 12	6 13	7 14	8 15	9 16	10 17	11 18	12 19	13 20	14 21	15 22	16 23	17 24	18 25	19 26	20 27	21 28	22 29	23 30	24 31	25 1	26 2	27 3	28 4	29 5	30 6		November *September*
December *September*	1 7	2 8	3 9	4 10	5 11	6 12	7 13	8 14	9 15	10 16	11 17	12 18	13 19	14 20	15 21	16 22	17 23	18 24	19 25	20 26	21 27	22 28	23 29	24 30	25 1	26 2	27 3	28 4	29 5	30 6	31 7	December *October*

Downloaded from Fountain of Knowledge Library

quickening" is sometimes used as a rough guide. This is when movements are first felt. But as this can vary between the sixteenth and twenty-fourth week, it is of limited value.

As time progresses, the doctor usually measures the height of the fundus. This means that he presses his hand into the abdomen to determine the upper extent of the growing womb.

The womb enlarges at a fairly constant rate, and the height, as it is called, usually coincides with the number of weeks of development of the baby.

For instance, at twelve weeks the fundus is just starting to edge above the symphysis, the front part of the bony pelvis. By sixteen weeks, it has risen to midway between the symphysis and the navel. It has reached twenty weeks when it rises to the level of the navel.

Every two weeks the rise increases by two fingers' breadth until it reaches the level of the navel. After this, it rises one finger's breadth each week.

This is nothing for you to worry about, but it is a good guide to the doctor. If the fundus is rising too rapidly, or if it is not rising at the normally anticipated rate, it means that all is not well, and investigation may be required as to the reason.

In some larger centres a relatively new concept of early recognition of pregnancy is being used in the form of ultrasound. In fact some centres claim it may be accurately diagnosed on the fourteenth day. Later on, head measurements may be carried out which can give accurate age assessments. However, these methods are not being used widely at present, but in the future, they may see a major surge forward as a method of early diagnosis, and monitoring of the foetus.

PRENATAL VISITS

The importance and significance of regular prenatal visits to the doctor or clinic cannot be overstressed. It is essential that attendance be made as early as is practical. If there is any question of pregnancy, then a visit is obligatory.

The initial visit sets the pattern for the future. But besides this, it gives the doctor a series of base-line figures with which he can compare your medical status at subsequent visits. This can be of inestimable value, particularly if complications set in at any stage—and this is a probable likelihood with a certain number of people. There is no knowing at the start if you are destined to be one of those special "at risk" persons.

There are three major aims for following through with adequate antenatal care. These are:

(1) To make sure that the mother reaches the end of pregnancy as healthy (or maybe even healthier) as she was beforehand.

(2) To detect any physical or psychological defect as early as possible and correct this promptly.

(3) That the mother is delivered of a healthy, normal infant.

It is only in the past fifty years that as much attention has been paid to the forty weeks of pregnancy as is paid to the fourteen hours or so of actual labour.

The value and beneficial result of this is reflected in the major decline in mortality figures, both for mothers and new-born babies. In fact, it only requires a quick glance at the striking reduction to be aware of the true benefits of today's insistence on adequate prenatal care.

If you have ever had the time or opportunity to wander through the yard of an old church, this will be impressed on your mind even more indelibly. Most old churchyards had the cemetery as part of the general premises. A check on the tombstones indicates the large number of very young children (and often young mothers) who died, no doubt in childbirth or soon after. Historical novels, and even tales from older members of families, will recount the disasters of yesteryear which regularly overtook the small children and babies in almost every family.

They were, in truth, the bad old days. Proper antenatal care was either non-existent or very skimpy. Midwives did their best. Doctors were often ill-equipped, and tiny cottage hospitals were quite hopeless in their attempts to cope with anything but relatively normal deliveries. Antibiotics, safe and adequate anaesthesia, safe methods for blood transfusion, blood typing and cross matching, and methods for foetal monitoring were still a long way off in those days.

Use the Available Help

The level of obstetric sophistication today is very high, and it is necessary for a prospective mother to take every advantage of what is available. Nobody can make you attend the doctor regularly. Nobody can force a person to make full use of the excellent services that now exist. It is up to the individual.

For women with a normal pregnancy, attendance at the doctor's surgery every four weeks until the twenty-eighth week is recom-

Downloaded from Fountain of Knowledge Library

mended. After this, fortnightly visits should take place until the thirty-sixth week. Visits then become weekly occurrences until the baby is born.

In the event of problems arising, then visits will be more frequent. This will be left to the doctor to tell you when he expects you to return for a subsequent check.

Do not go against your doctor's advice. Do not think you are somebody extra-special, who can be excluded from the need of proper regular medical examinations. Just because you have experienced hardly a day's illness in your life does not mean you can shirk on your requirements right now. Stick with the routine. Follow your doctor's advice exactly in every respect. In this manner, you will be guaranteed a safer, more comfortable confinement than otherwise. It also means you are being fair to your unborn baby. After all, at this stage you are totally responsible for his welfare as well as your own.

THE FIRST VISIT

We have already pointed out some of the things the doctor will look for at the first prenatal visit. If your own doctor carries out the total care of the confinement himself, he will no doubt perform a complete examination at the first visit. Or if you are referred to the obstetrician, he will most likely perform the full routine on the first occasion.

This is what you could expect to take place:

(1) *History of the Present Pregnancy.* The doctor will check your L.M.P. He will ask about details of symptoms you may be experiencing, in an effort to pinpoint whether you are or are not pregnant. In many cases it is quite clear and fairly obvious that you are pregnant.

(2) *History of Previous Pregnancies.* The doctor will be interested to know about previous pregnancies, whether they proceeded to full term, or ended up as miscarriages or abortions. He will want to know about any special difficulties that occurred during the pregnancy, or afterwards. Also, if the babies were normal, weighed the normal weight, and the approximate duration of each labour. All this will assist him when it comes to assessing the present case. He will also question you about blood transfusions.

(3) *History of Past Illnesses.* As certain diseases may be of significance, he will query you on past and present illnesses. Diabetes, heart and kidney disorders may be very important.

(4) *Physical Examination.* The doctor will then carry out a full physical examination. Each system is checked. The heart, lungs and intestinal system are examined, as well as each other system in brief. The breasts and nipples are checked. The doctor will be keen to know your average weight before you became pregnant. He will weigh you, check your height and blood pressure. In fact, the regular blood pressure readings form one of the most important checks thereafter. It is essential that the doctor have a "base-line" reading with which he can later compare subsequent readings.

(5) *Pelvic Examination.* The doctor will insert an instrument called a speculum into the vagina. This gives him an excellent view of the vaginal passageways, and the cervix, the part of the womb that juts into the upper part of the vagina.

He will inspect each part thoroughly. If there are discharges, he will probably take a specimen for pathological examination.

A cervical smear test will probably also be done, and this too will be later sent to the pathological laboratory for examination.

This is followed by a manual examination. In this way, the womb can be felt by the examining fingers. Abnormalities may be detected which could play an important part later on in the pregnancy. The size and position of the womb is felt and recorded.

(6) *Laboratory Tests.* Besides the tests already mentioned, the doctor will arrange for certain important tests to be carried out. These will usually include various blood tests. A haemoglobin estimation is performed. This indicates the quality of the blood. If reduced, it may require treatment.

The blood group must be known, for this could be vital later on in the event of abnormal bleeding. It is called the "ABO" grouping. In addition, the Rh (or Rhesus) factor must be known. This is also very important for all women, but especially in the cases of mothers pregnant for the first time. Today, it is possible to prevent many of the disasters of yesteryear when serious complications occurred due to this blood factor. Modern medical progress has now virtually eliminated these serious problems from arising by treatment before they occur. More will be told about this later on. The key factor is the need to know the patient's Rh factor.

The Wasserman or Kahn test (to check against venereal disease) is performed, and a urinalysis carried out. This is a simple urine test for certain elements that could adversely affect the

Downloaded from Fountain of Knowledge Library

pregnancy (mainly albumen and sugar). Sometimes a special culture of the urine may be ordered if the doctor has any suspicion that infection is present in the urinary tract.

Some of these tests will be carried out at the doctor's office. Others may necessitate a visit to the pathology department of the hospital or to the rooms of a private pathologist. Sometimes the doctor may take the blood sample himself and have these sent to the pathologist.

If there is any doubt about pregnancy, the pregnancy test may be carried out as well. This is the check for H.C.G., which has already been explained. (See pages 68, 69.)

(7) *The Next Visit.* An appointment will be made for your next visit which will be in four weeks' time. Subsequent visits will be quite a deal briefer than the initial one.

They will chiefly entail a check on the blood pressure, a urine check (mainly for the presence of albumen, which if present is an indication of abnormal kidney function), and weight gain.

The mother-to-be will have the opportunity of telling the doctor of any abnormality that she has noted. He will offer appropriate advice.

After the twenty-eighth week, examinations tend to be more comprehensive. The doctor will carry out an abdominal check as well as the foregoing procedures. He will assess the height of the fundus, and this gives a good indication of the rate at which the infant is growing.

He will also check the position of the foetus as it lies in the womb. He can readily work out where each part of the body is, where the head is located, the back, and breech (or rump). He will listen for the foetal heart sounds through a special obstetrical stethoscope, and check on its degree of activity. All these are important features, and variations from the normal may need to be followed through with other investigations.

Every doctor, of course, sticks to the routine he has found most practical over the years. So if your doctor has a routine which differs from this one, do not be alarmed. There is little doubt that all the important features will be covered bit by bit. He may elect to carry out certain examinations earlier or later. It depends on his individual feelings at the time, so go along with his suggestions at all times.

Later on, certain additional blood tests may be ordered. If the blood count or haemoglobin levels were unsatisfactory at the first assessment, then it is certain these will be rechecked once or twice later on.

If there is any question about Rh factor problems, later checks may be required for this as the pregnancy moves on.

SIGNIFICANCE OF CHECKS

Every check is carried out for a particular reason. This is to make certain mother and the developing infant will remain safe throughout the pregnancy and will be well and healthy at the termination of the confinement.

Tests are never carried out haphazardly and just for something to do.

The weight measurements are important. The mother-to-be should not gain more than 0.5 kg a week. If she exceeds this, it may indicate an increased risk of subsequently developing eclampsia, one of the serious complications of pregnancy.

Similarly, blood pressure readings are very important. Many doctors regard a reading of 140/90 as the upper limit of normal. If pressure readings start to rise above these figures, it is a cause for concern and action. Once more, a serious complication of pregnancy is characterised by a sudden rise in blood pressure. The only way in which this can be recognised is by the regular readings carried out accurately on a systematic basis.

Urine tests seek out a substance in the urine called albumen, which is a protein substance. If this appears, it indicates that all is not well, and that immediate action is necessary. Once more, it can be the warning signal that serious medical complications may be starting, and action becomes imperative at once.

Blood checks are important. The haemoglobin level gives a clear, accurate assessment of the mother's blood quality. This is done at the start. If it shows a reduced level, special treatment may be prescribed to bring it up to the normal level.

But a recheck later on is usually recommended. So, reassessments may take place occasionally, depending on what the doctor considers necessary.

From time to time, the doctor may consider other tests are needed. Whatever occurs, he will make certain requests depending on the situation at any given visit. Go along with these requests. They are all given in your own interest, and the best interest of your baby that's in the making.

When everything finally turns out the way you had hoped, a lot of this will be due to your own efforts, as well as the efforts and recommendations of your doctor. So stay with his suggestions at all times.

Downloaded from Fountain of Knowledge Library

Downloaded from Fountain of Knowledge Library

Chapter Three:

The Practical Benefits of Correct Thinking

Steering clear of troublemakers and ill-informed (but well-meaning) friends is essential. A forceful, positive mental approach is likewise essential. It's a fine time to tell your children the facts of life. Learning relaxation now helps when labour starts.

Pregnancy is a very normal situation. You are certainly not a "patient" in the sense that a patient is receiving medical attention due to an illness. It is a normal, natural part of life, just as eating, sleeping and exercising are normal, everyday aspects of healthy living.

Pregnancy is merely the sudden use of a specific part of the body that is only used at certain times. It is simply an onward progression of natural sexual habits.

Women are strongly advised to consider pregnancy in this light. Once they are convinced that it is a natural phenomenon, many of the bizarre preconceptions that often enshroud pregnancy—even in these modern days—will be immediately swept into oblivion. That is the best place for them. They have no place in this modern, second half of the twentieth century.

But, strangely, old ideas die hard. A solid core of problem-mongers still linger with us, perpetuating strange fantasies and fallacies of a bygone era. Fortunately, however, one of the beneficial effects in today's era of enlightenment and free talk about sex, is the gradual eradication of many of these old-time, foolish ideas about sex and sexuality.

By becoming pregnant, you are not becoming an invalid. You are merely entering another phase of feminine living. And an exciting and mentally and physically rewarding one at that. Never forget this. Get it etched indelibly on your conscious and unconscious mind. Let it remain there forever. This way you are helping to fortify yourself against nonsensical information that may come your way during your pregnancy. Certainly it will not entirely remove every obstacle. But, thinking is an important facet of everyday living, and the pregnant woman is no exception.

"As a man thinketh, so is he," the Good Book states. That applies to many facets of everyday living. It includes pregnancy, I am certain, although no specific mention is made of it.

Think Success

Think happy thoughts of success, and the chances of success and positive achievement are more likely to come your way. Think dour, unhappy thoughts of sadness, or pain and suffering, and just as surely, you are more likely to run into trouble. There is little doubt of this, as countless thousands of women have testified.

Nobody has told the animals that their

Downloaded from Fountain of Knowledge Library

confinements are to be filled with pain and suffering and horror, so they usually glide through them with complete ease. Numerous native tribes, "uneducated" by our standards, have never been told to expect hardship, agony and the tortures of the damned when they are reproducing, so they do not look for it. And according to numerous reports by on-the-spot investigators, they undergo very little physical or mental trauma when their time arrives.

"It's all in the mind." How true! So, from the moment your pregnancy is confirmed (and preferably well before that date, when you have the first intimate inkling yourself), start to programme your mind correctly. Do it regularly, preferably every day, many times every day.

"This is normal, natural, and I intend to enjoy every living moment of my pregnancy," you tell yourself in terms loud and clear. Repeat the message many times during the day, and just before you go to bed at night. Repeat it if you awaken during the night, and say it again first thing every morning.

Gradually, with this incessant input of positive, happy, successful ideas, your subconscious mind will automatically become programmed to expect the best, to expect success.

The psychological benefits of sensible, positive, practical programming of the mind cannot be overexpressed and re-emphasised.

Try to live a sensible, normal, natural life. Do not mollycoddle yourself. This is tantamount to failure. Nature will certainly "deliver the goods" in due course. But you are doing yourself an injustice to become introspective and introverted at this vital time. It is a time to enjoy, to be happy.

Not only is it a time of happiness for you, but it should be for all the family as well. Your husband will be delighted to see your enjoyment and zest for living increase. If there are already other members in the family, let them in on the secret as well. There is nothing so delightful as "togetherness" when another member is anticipated.

Education for the Family

Besides this, it offers one of the most beneficial opportunities you will ever find to explain to your children the so-called "facts of life."

It depends to a certain extent on the age of the other offspring. But it is surprising how intelligent in these matters even very young children happen to be. They are unusually observant. Even toddlers are geared for absorbing sounds and sights in their environment. Indeed, this is all part of the growing-up routine. It is nature's way of establishing in their minds sets of standards which will stay with them for the remainder of their lives.

Most will come to recognise the gradual alteration in the shape of mummy's tummy. Questions will be posed. The simplest and easiest way out is to offer straightforward, honest answers.

Tell them Mummy is expecting a new baby. Let each member touch the expanding stomach. Let him feel for himself, and have a listen. Children's tactile senses are very acute. They can readily sense internal movements as the foetus moves about. This will give them an amazing sense of pride and happiness.

If the opportunity arises, and in many cases it will, explain in some detail how baby got there. Don't be shy and embarrassed. Your children will not be, so why should you?

Show Them

Show them how the little seed got inside. Indicate how baby will get out. Don't point to the navel and say "through there." It's done by unthinking mothers-to-be every day of the week, and it is foolish. Make the most of every opportunity, and you will never be embarrassed to discover that your children one day will be sat down and told the facts of life—perhaps crudely and by some precocious child.

You will have already told them, little by gentle little. This is the most natural, effective and beneficial way to present the story of life, of sex and reproduction to your growing family. Grasp every opportunity, and make the most of the situation while it lasts.

At bathtime is often a good time. On such occasions, everyone is peeled down to the bare essentials. It can be an excellent opportunity for a highly profitable discussion of the body, its functions and potentials.

Even in these enlightened days, enormous numbers of youngsters still do not get a comprehensive story of sex and reproduction. They learn the hard way, the questionable way. Magazines and popular books abound. But so many give only a garbled version of the seamy side, the sensational, and dwell abnormally on sensuous gratification, that too many young people consider this to be the only side to the picture.

The simple words of a pregnant mother, talking to her young children in words that they

Downloaded from Fountain of Knowledge Library

can understand, will often form the basic framework on which a sensible, reliable understanding of sex in all its true beauty may be imparted. Use the opportunity as often as it arises.

Youngsters, even in early childhood, are accumulating their yardsticks and values. They face life honestly. They will accept, usually without question, information imparted to them.

Give Honest Answers

So take advantage of this. Give them honest answers. Do not pretend, do not fool, do not be dishonest. In this simple way, you may be establishing very important subconscious masses of important data in the memory banks of your children. It will serve them well for the rest of their lives, whether you recognise the fact or not. So, be natural, direct and as forthright as the age of the child indicates. It will pay handsome dividends.

Do this and the terrible day when you feel obliged to tell your child the facts of life will never eventuate. He will already know them. He has built on the basics you provided, and has a clean, intelligent outlook on life. In today's world, this is of inestimable value.

Participation of the Mother-to-be

In recent years, more and more attention is being focused onto the natural aspect of the entire procedure of pregnancy. Although set routines are carried out in most obstetrics hospitals, many large women's hospitals now encourage active participation in the confinement by the mother herself. By sensible, simple training beforehand, much can be done to alleviate the fears and phobias that many women harbour.

A system which goes by the name of "Psychoprophylaxis" is becoming more and more widely used. It is mentioned here not with the intent of replacing normal obstetrics practice with it, but because it is such a sensible system that many women are now anxious to try it.

In many instances it finally allows delivery of the baby with the minimum use of drugs. In fact, the proponents claim that 45 per cent of patients using the system do not need any injections of the usual pain-killing drugs (such as pethidine). About 45 per cent may require one single shot (or at most two). The remaining 10 per cent do not seem to receive much assistance from the method.

The system is widely used in some Continental countries. The Russians claim that more than 90 per cent of their pregnant women stick to the system, and a reputed 70 per cent of French women are claimed to follow it. It is all wrapped up with the mental approach to pregnancy, and ultimately to the delivery of the baby itself.

As we all know, many women are still plagued with the basic conception that pregnancy is an illness, and that the confinement must be painful. For this reason, because they expect it to hurt, it will hurt. It becomes a "conditioned reflex." This has been a well-established physiological theory for many years, and is nothing new. So the unlucky woman becomes pregnant; she anticipates the worst, and pain and suffering become her lot forthwith.

But, with sensible training, this conditioned reflex can be removed, and successfully replaced by a new one. So, when the chips are ultimately down, sensations which would normally be interpreted by the brain as pain, are no longer given this interpretation. The sensations are automatically converted into "motor activity."

Downloaded from Fountain of Knowledge Library

In other words, action supplants fear and pain.

From the practical view-point, this is briefly how the system is put into operation:

(1) *The Conditioned Reflex.* The expectant mother attends a series of simple lectures. These clearly describe the process of childbirth and what will happen at the time of her confinement.

In words she can understand, the "conditioned reflex" idea is presented. It is shown how her response to stimuli can be increased, reduced or altered.

She is taught that the "Pains" that herald the onset of labour are really a signal for her to start playing her part in the act. She immediately starts to follow a series of specially taught breathing exercises. In this manner, by concentrating on her breathing, her pain threshold is immediately raised. The cycle continues, so that she becomes a trained participant in a situation, rather than a passive, frightened acceptor who fears the worst and probably will end up experiencing the worst.

In this manner, the need for drug therapy to quell pain is usually markedly reduced. Experience shows this is frequently what takes place.

(2) *Breathing Exercises.* This is a key routine that the patient learns during the second half of pregnancy. The exercises come in two forms. The first type of breathing is designed for the early stages of labour. The second type is scheduled for the latter part of labour and the delivery.

Breathing is first slow and relatively light. It increases in depth and rate as the contractions increase and the "Pains" become more severe. Quick, shallow breathing is interspersed with the breath being blown out at certain intervals. These breathing exercises are interspersed with light, stroking movements with the fingertips over the abdomen or sacral areas. The idea is to further increase mental stimulation.

She is also taught to give her utmost in physical co-operation, particularly in the later stages.

(3) *Neuro-muscular Control.* The patient is taught during the prenatal classes that stimuli must travel from the brain to the muscles. While one set of muscles is contracting, she is told, other sets are relaxing. In this way, it is possible for her to gear herself so that specific sets of muscles are either in a contracted or relaxed state.

Certainly this requires a considerable amount of education. But in a well-trained person, the results can be very gratifying. In later labour, a proficient person may be actively assisting by contracting her abdominal muscles, and at the same time actively relaxing her pelvic floor muscles, so assisting the birth of the baby.

The net effect can be extremely rewarding. But the patient needs assistance and tender co-operation throughout the procedure. Those who have undertaken this system claim it is an exhilarating sensation. Most claim the best part is when the baby gives its first lusty yells, and the mother is fully aware, in a happy state of drug-free consciousness, and can appreciate this tender moment. Indeed, many claim it is a situation which is etched indelibly on their mind, and can be fondly remembered.

Of course, it is essential that adequate drug therapy and the usual forms of standard obstetric practice be readily available in case the mother suddenly finds she cannot cope. An attentive staff, trained to both systems, are well aware of these possibilities.

However, the system is worth considering, as more and more obstetricians all over the world are starting to phase the system in. Some doctors will not have anything to do with the relatively new ideas (although they have now been around for quite a few years).

At least, it offers women another form of obstetric care, and can easily be slotted in with normal procedures.

It seems to fit in so well with a natural approach to baby care, and a relaxed mind that is so important.

In some large city hospitals, the methods are taught in classes, and this is perhaps the best way to approach the matter. But following psychoprophylaxis in no way invalidates the other recommendations already made about general care of the body, regular medical attendances and so forth, for the prospective mother. These are vital, irrespective of the method finally used in the labour ward.

Downloaded from Fountain of Knowledge Library

Chapter Four:

Sensible Care Pays Off

Better health means fewer problems for you and your baby. Here are some helpful hints that will help you both.

Normal pregnancy can be lots of fun.

There is no need to treat it as a time of abnormality, or difficulty or peculiar hardship. In fact, the more "normal" and "natural" it can be regarded in all aspects, the more normal and natural it will prove to be.

Many difficulties are predominantly in the mind. Think right and act right, and the entire excursion will be a pleasure that you will recall with tenderness for many years to come.

There are so many foolish notions still abounding that many younger women have an intrinsic fear nagging at them from the moment they conceive.

This is frequently accentuated by vociferous, but perhaps well-meaning acquaintances. (They could not be called "friends.")

If you hear these voices of despair, ignore them completely. Cut off these people from your list of social contacts. You are far better without them and their despairing talk of failure and difficulty. There is no place for negative thinking when a baby is coming to your house.

The entire procedure must be surrounded by an atmosphere of success, of achievement and, above all, happiness. By thinking in this manner, and acting accordingly, your life will be a pleasant one, and the end-product will be one of which you (and your family) will be proud.

The key to living over the next several months is an accent on normal. "I am normal in every respect," you may tell yourself regularly. "This is one of the greatest events of my life. Every day will be another milestone in the course of my pregnancy. I intend to make it a happy day. I intend to live normally in every respect."

This is the first approach. Then, live up to what you tell yourself. Your doctor will tell you the same thing, even though he may use different words.

Now, seeing everything is so nice and normal, consider some of the corollaries of this.

EXERCISE

The recommendation is to act normally. If you are a keen follower of participation sport, then continue with this by all means. There is absolutely no need to mollycoddle yourself as if you were suffering from some debilitating internal illness. You are healthy, fit and well. So, get with whatever you normally enjoy in the exercising or sporting area. This applies to fairly vigorous activities as well as those requiring less effort.

If you are a keen tennis player, play on. If you follow squash, vigoro, skating or whatever, so much the better. There is no reason why activity need be curtailed.

Downloaded from Fountain of Knowledge Library

Just to be on the safe side, some doctors suggest a slight curtailment of vigorous activity on the occasion when the first four menstrual periods would normally take place. This can be simply calculated and borne in mind. But others do not think it is important. If there is a tendency to previous miscarriages, then the rule might be applied a little more seriously.

Swimming and surfing likewise may be followed in a normal, natural manner. Many women, particularly on the Australian and New Zealand scene, are very enthusiastic on these sports. Swimming activates nearly every muscle in the system, and is good, wholesome activity.

Surfing has similar advantages, as well as the added value of acting as an external massager of the entire body. It is a fine activity, and does much to keep the body in tip-top tone and physical condition.

Walking, running, jogging and similar activities can also be followed as in the pre-pregnant days. However, many other women are not attracted to vigorous sporting activities. Then, there is no need to start energetically to engage in such enterprises. There is no great benefit to be derived from a sudden increase of physical exertion if this is not what the system is usually accustomed to do.

Becoming a sudden fanatic for exercise for the sake of exercise (or for the sake of the baby, as some will declare) is foolish. At the same time, there is no point in becoming a physical cabbage. A sensible in-between level can readily be followed.

CLOTHING

What sort of clothing should a pregnant woman wear?

The answer is simple. Wear clothing that suits you, your personality and the way you feel at any given time. Wear the type of fashions that enhance your looks and suit your personality.

In this way, you will look more natural, and more attractive. If the mirror smiles back at you, this can do much to improve your own psychological outlook—such an important factor during pregnancy. In turn, this is certain to evoke words of admiration from your spouse, and probably from other members of the family as well.

As far as foundation garments are concerned, this too depends on how you feel. Most women will feel more comfortable wearing a good-fitting brassiere. But in these days when many younger ones have "burnt the bra," and strongly follow women's lib and similar movements, some may prefer the apparent freedom that a bra-less torso gives them.

Too tight, too uncomfortable.

Elasticised abdominal garments may be worn if this imparts a feeling of comfort or mental satisfaction. Many brands of panty-hose have elasticised girdle tops, and these are often just as adequate. But other women prefer not to use these either.

If previous pregnancies have produced very slack abdominal muscles, then some type of support will often prove to be very comfortable. It is mostly a matter of personal comfort and personal taste.

Footwear can be used to suit. As pregnancy advances, the centre of balance tends to alter so that high-heeled shoes become a problem and cease to be comfortable. So, low-heeled shoes are preferable. Care to avoid extremes in footwear is advised, especially as some footwear is fad-wear, and can easily predispose the wearer to tripping, slipping and falling. Common sense should be the rule.

Downloaded from Fountain of Knowledge Library

DENTAL CARE

It is worth while visiting the dentist early in the pregnancy. It is to your advantage to have abnormalities rectified. Decayed teeth and holes should be attended to. This will assure you of an improvement in general health. But it will also help check the sudden onset of toothache and other dental problems during pregnancy. There are enough matters to contend with during the final stages of pregnancy without a sudden, unexpected toothache. And this is not an uncommon situation.

Dental work is best carried out during the middle three-month segment of the pregnancy. Done in the early months, the use of drugs which may be involved is not recommended, and in any event bacteria may be spread from infected areas. In the latter months, the sheer inconvenience of actually sitting in a dental chair can make it a less than comfortable experience.

MARITAL RELATIONS

All couples want to know about normal marital relationships. The general advice given is that there are no restrictions on these activities at any stage. Intercourse is best avoided at the time when a menstrual period would normally be expected for the first four missed periods. There is a very slight chance that it may precipitate a miscarriage, although the risks are not high.

During pregnancy, the increased hormonal production in the female may have varied physical and emotional effects. Some find their sexual sensations are heightened, and there is an increased desire to make love. In others, there is a reversal of these feelings. They find that the thought of sex is less and less inviting, and some completely "turn off" altogether.

Husbands, I hope, will read this important message. Unfortunately, many unthinking males interpret this as a sudden cessation of affection for them, on the part of their spouses. They do not realise that chemical influences over which they have absolutely no control are the real basic cause, and it has nothing to do with their wives' true feelings.

Husbands would do best to accept quietly this temporarily altered state of affection, and put it down to the pregnancy, the true cause. In due course, the entire situation will change back to the usual, normal, happy state once more. Making scenes, and acting in a childish fashion over this does nothing to improve the situation. Indeed, it can cause a rift that might easily widen as the pregnancy advances.

Pregnancy is a time of togetherness and pulling together. This applies in sexual matters as well as in all other respects, and both parties should remember this.

Conversely, the wife should not use her feelings and sex as a weapon against her husband. Both should be geared to act as normally and naturally as possible at all times. This way, common sense and warmth and greater affection one for the other will prevail.

TRAVELLING

No restrictions are placed on travel, provided this can be carried out in a leisurely manner without any undue stress or strain being placed on the woman.

However, it is wise to consider the possible implications of long journeys. Undertaking excessively long motor trips, for example, across a continent, possibly including areas where facilities are poor, would not be wise, especially in the later months of pregnancy.

Similarly, embarking on long-haul jet journeys in late pregnancy is unwise and fraught with possible difficulties. In recent times in Australia two such women on different journeys suddenly went into labour and had their babies born seven miles up in the sky! As it so happened, doctors and trained sisters were passengers in both instances and were able to deliver the babies safely and without harm. But there was no margin for error, no room for complications.

As every obstetrician knows, a certain percentage of cases are statistically guaranteed to produce complications at delivery. So why tempt fate, why run the risk (to yourself as well as to the infant) by doing foolish, indiscreet things when they are unnecessary? Be sensible, and the chances of risk diminish appreciably.

SMOKING

Here we come to a very important topic. Over the past few years, the facts relating to deleterious effects of smoking on both the mother and the unborn baby have gradually accumulated. Now it is very well documented that smoking is considerably harmful. This affects the mother. But the adverse effect is even greater on the baby.

Cigarette smoke contains three essential ingredients.

(1) *Carbon Monoxide*. When this unites with the blood, it forms a potent chemical called carboxyhaemoglobin. It links with the haemoglobin, the red material of the blood that normally transports oxygen to all parts of the system. In

Downloaded from Fountain of Knowledge Library

this way, the oxygen-carrying capacity of the blood is drastically reduced. This is one potent way in which cigarette smoke damages the body in general.

But when this oxygen-reduced blood reaches the placenta, and the blood circulation of the growing infant, reduced amounts of oxygen are available for use at the vital centres. Extremely damaging effects can occur, and the results are serious to the infant. Many detailed studies have now been carried out in major maternity hospitals in all parts of the world which testify to the same net effect.

(2) *Nicotine*. This is a powerful nerve stimulant. But while it is stimulating the nerves, consider what it is doing to the blood vessels. It can act directly on the blood-vessel walls, causing them to contract, and this may initiate a rise in blood pressure. Such a situation in the pregnant state is definitely undesirable. Besides, a net detrimental effect on the heart and blood-vessel system can accrue from a continual supply of nicotine being pumped into the system. It is adverse for the baby to receive this drug also, and this is inevitable with continual maternal smoking. Smoking is never a virtue; during pregnancy it is doubly harmful. No expectant mother who has any consideration for her unborn child will indulge in the habit.

(3) *Carcinogenic Agents*. These are a complex number of powerful chemicals which are known causes of cancer. During the baby's nine-month stay inside the maternal womb, the chances of cancer formation are not high. But the continual irritation of the mother's bronchial system with these irritants does little to maintain the general high level of health which is essential during pregnancy.

So the evidence is definitely very positive, very real. It is no longer a fanciful whim of doctors. Indeed, about 75 per cent of doctors who once smoked have given up the habit. This is due to general consideration of their own better health. Even more important is it that mothers carrying a developing foetus desist from the habit. Please don't say, "I can't give it up." If you care about your baby, you *must* give it up. Please don't be controlled by a weed wrapped in paper!

The Dangers

The major medical journals are continually publishing further evidence suggesting an increasingly widening range of possible serious side-effects to both mother and baby as a result of smoking. Here are just a few of the well-recognised dangers:

Miscarriage. There is a greatly increased risk of miscarriage. This is probably due to inadequate amounts of oxygen being available to the developing infant due to carboxyhaemoglobin formation at the lungs. Carbon monoxide competes successfully with oxygen, and oxygenation of the blood is prevented. So, the baby virtually suffocates, dies and is expelled.

Premature Births. This means the mother comes into labour earlier than would be expected. In many cases this still produces a normal baby in due course. But there are increased risks. Babies are meant to remain in the womb for nine months. Variation from normal inevitably increases risks.

Underweight Babies. Premature births usually mean babies weighing less than normal. This means they have decided disadvantages from the start. They commence life in a retarded physical state. They are less equipped to cope with the rigours of living in the world. They are more prone to adverse risks, and the mortality rate rises.

Increased Peri-natal Deaths. The death rate of babies of smoking mothers soon after birth is greater than it is for mothers who do not smoke. This ought to be given serious consideration.

Mental Retardation. Recent evidence on the long-term effect of babies from smoking mothers indicates that years later, these children compare adversely with the children of mothers who did not smoke. Mental acumen and ability are less. In some instances the difference was not major. But in this increasingly competitive world, when the emphasis is on mental acumen and educational achievement, this may play a greater part in the long-term achievements of the growing child.

Infections. Smoking mothers tend to continue to smoke after the baby is born. Once more, the deleterious effect on the baby, who is forced to become a "passive smoker," is very real. Not only does he suffer the same risks as a smoker, but there is a definite increase in the rate of respiratory tract infections that he will acquire during his childhood as compared to children of non-smoking mothers. This could predispose him to the many ailments that continual respiratory disease imparts, such as bronchitis, asthma, etc.

It has been fairly well documented that ten cigarettes smoked by a person in an enclosed room is the equivalent of a "passive"

Downloaded from Fountain of Knowledge Library

non-smoker situated in the same room actually smoking one cigarette.

A baby's respiratory system is simply not geared to the intake of cigarette smoke, filled with the dangerous toxins that have already been enumerated.

It is vital that mothers do not smoke. If they do smoke, they should get in touch with some system that assists in reducing or completely stopping the habit. Several excellent plans are available in most countries of the world.

One very successful system is known as the 5-Day Plan. It is possible to undertake this simple, successful system, and by writing to the publishers of this book details of the system and where it is available in this country will be forwarded. Alternatively, check in your phone book under 5-Day Plan to Stop Smoking. All capital cities and many rural towns have contact numbers for further details. 5-Day Plans are often run at certain major hospitals as non-profit community efforts. They have chalked up remarkably successful records in the several years they have been in operation on a world-wide basis.

ALCOHOL

Prospective mothers are certainly better off reducing or completely eliminating alcohol from their diet during pregnancy and breast-feeding. It is better for their general health, and it is in the best interests of the baby.

In recent years, many maternal research centres have published documented evidence of the deleterious effect alcohol may have on the baby. A condition called fetal alcohol syndrome is becoming more and more common. This produces adverse physical and mental defects, and the child, if he survives, may be mentally defective for life. Many severe cases end in death.

Doctors have now stated categorically that alcohol in any form and in any amount is definitely not recommended during pregnancy. The risks of a defective baby are too high, short-term as well as long-term. Not long ago, the College of Psychiatrists claimed that alcohol is now considered to be the most common cause of mental retardation in babies of the Western world.

The greater the consumption of alcohol, the worse are the effects. Indeed, many instances have been reported of severe deformity, mentally and physically, to the baby.

It is also worth noting that beer contains the least concentration of alcohol; spirits (whisky, etc.) the highest concentration. So, if drinking habits are continued, then drinking the smallest amounts of the least harmful type of alcoholic beverage is best. However, sensible women find that they find more pleasure in replacing alcoholic beverages with tangy, fresh fruit juices or even chilled fresh water. Fresh fruit juices are often rich in vitamins, and these could help provide the vitamin needs of the parent and the developing infant.

IMMUNISATION AND VACCINATION

Some women may find it necessary to travel overseas during their pregnancy. The question relating to the need for vaccination against various diseases arises.

Ideally, vaccination should not be carried out during the first three to four months of pregnancy.

Primary smallpox vaccination is not recommended until at least the twentieth week. However, with smallpox virtually eliminated from the world, few countries now insist on vaccination against this. It is not required for re-entry into Australia, New Zealand, Britain or America.

Protection against cholera and typhoid is claimed to be safe, but many doctors would prefer not to give these vaccinations either during the first three-month segment of the pregnancy.

Revaccination against poliomyelitis is claimed to be safe.

OTHER PRECAUTIONS

There are certain other precautions that are essential during pregnancy. In fact these are so important, and can play such a vital part in the development of the foetus that they are considered separately in the following chapter. Please read the next few pages very carefully, for it is highly likely that the information may be pertinent to you.

Downloaded from Fountain of Knowledge Library

Chapter Five:

There Are Certain Risks. Beware!

Some common but avoidable risks may be just around the corner. To be forewarned is to be forearmed. Take heed, and simple awareness may save major heartache.

In recent years, increasing evidence is indicating that very real dangers exist for the unborn baby under certain conditions.

Many of these situations are now well established. Many are completely avoidable.

However, some women are either completely unaware of the possible hazards, or are only slightly aware that these risks exist.

Seeing they are so important, as a follow-on from the previous chapter where general advice and precautions were outlined, these especially important warnings are being listed in this section.

Women who are pregnant, or who are contemplating pregnancy, are advised to study this chapter carefully, for the information given is up-to-date and very important. In fact, it could either make or mar an otherwise happy pregnancy. It can affect anybody at any time at any place. Nobody is immune. Every week, the world-wide medical journals—the chief method of informing doctors about new developments—publish fresh information testifying to the importance of these factors.

Some of this information has been known for some years. But in many instances, more recent documentation has strengthened and widened views previously held.

Other information is fairly new. The passage of time, in the future, will no doubt give further weight to much of it. It may modify or alter some of it. But it is more likely to reinforce ideas currently held.

The points to be discussed mainly involve substantial risks that exist for the unborn infant.

It is well known that enormous activity occurs with the developing embryo during the first eventful weeks. During the first ten weeks, "organogenesis" is occurring. Cells divide, redivide and gradually develop to form the vital organs of the mature infant. Indeed, it is incredible the speed with which this takes place.

After the first ten weeks, the process slows down. But cell division and redivision continues at a less rapid rate for many more weeks. Indeed, new cells are being formed right until the moment of birth.

It is during this time of rapid cell division and organ formation that the embryo is at a very special risk.

If it is exposed to certain abnormal influences during this period of time, severe disasters can commence.

In turn, by adversely affecting cell division, disorders that are collectively termed congenital abnormalities can readily occur.

Downloaded from Fountain of Knowledge Library

Here are some of the chief ways in which this can happen.

VIRUS INFECTIONS

(1) *Maternal Rubella*. Some years ago an Australian eye surgeon named Norman Gregg noticed an apparent relationship between women who had suffered from the common and relatively innocuous viral infection called rubella (German measles) and certain eye abnormalities in their babies.

This prompted him to study the situation much more closely, and this was the beginning of one of the most important discoveries of recent times on the maternity scene. Gregg's early studies have had world-wide repercussions of major magnitude since they were first enunciated.

Little did he realise when he published his original report in an Australian eye magazine that he was touching the tip of a giant iceberg. In fact, the results are still being felt, as the general principle is still being investigated in many allied fields.

Gregg's basic discovery was this: The mother became infected with rubella, an innocuous disease in itself, producing a mild rash, a few swollen glands in the neck, and maybe symptoms of a mild cold. But, the mother's system harboured the germs in profusion. Some of the viruses crossed over the "placental barrier" and gained access to the developing embryo in the maternal womb.

Occurring during the vital first weeks of development, they were able to interfere dramatically with the cell division and organ development of the embryo. As time passed, it became very evident that the eyes were not the only organs to be adversely affected. The ears and heart were also prime targets.

It did not take long before Gregg's work received world-wide acknowledgment. In fact, major epidemics of rubella are now followed by an unfortunate wake of blind or deaf children or those with heart defects. Indeed, so serious has the situation become that a mother in the early stages of pregnancy who contracts rubella is considered to be a suitable candidate for a legal termination of her pregnancy. This is now a very widely held principle in many countries of the world.

Of course, many women still refuse to undergo this operation, and are often left with a deformed baby to rear. It is a sad event, but one which still occurs in large numbers of cases throughout the world.

It has been calculated from major epidemics in many parts of the world that a woman who is pregnant and becomes infected with rubella will produce a congenitally deformed infant, or will spontaneously abort in 40 per cent of cases. If the infection occurs in the first six weeks of pregnancy, there is a 50 per cent chance of a major congenital abnormality taking place.

The lens of the eye, and the major parts of the ear develop in the embryo between the fourth and twelfth weeks. The chief chambers of the heart develop between the fifth and seventh weeks. Therefore, the importance of infections during these vital times may be appreciated.

In the light of these discoveries, it can now be stated with a fair amount of accuracy what abnormalities may be expected. For example, rubella occurring during the fifth and seventh weeks may produce cataracts in the eye. (This means the lens of the eye becomes opaque and the child is virtually unable to see.) Deafness will take place with rubella infection during the eighth to ninth weeks. Heart abnormalities occur with infections during the fifth and tenth weeks. It is now as clear-cut as this.

Treatment. Offering a woman a legal termination of the pregnancy may solve the short-term problem. But on the wider horizon, much can now be done for women in general.

The ready availability of rubella vaccination has changed the entire picture. The most satisfactory form of protection is for a girl to have an attack of rubella during childhood. This gives excellent protection from subsequent attacks. In many countries school-children in the age group when pregnancy is least likely are now offered rubella vaccination. This confers excellent immunity. It is by no means 100 per cent effective (as was originally believed), but it is certainly far better than no protection at all.

Older women who have not been vaccinated may receive vaccination provided pregnancy does not occur within the following three (or preferably four) months. With the universal availability of contraceptive methods these days, this is usually not difficult. If by some misfortune conception does occur within the three-month limit, then the foetus runs a certain risk, but it is much less. In 1981, a check on 100 pregnant women in America who were vaccinated during the first three months, showed no congenital defects at all. Officially the risk for defects is between 0 and 5 per cent. This contrasts sharply with between 20 and 25 per cent in completely non-immunised women who

Downloaded from Fountain of Knowledge Library

developed rubella in the first three-to-four months of pregnancy.

Because many women are completely unaware whether they have contracted rubella or not during their younger life, a specific test to check on this is available. It is known as the H.A.I. test, short for Haem-agglutination Inhibition test, and is readily and accurately carried out by pathological laboratories. It measures the body's level of rubella "antibodies," specific elements that confer protection. So, if there is a high level of antibodies, then the woman is fairly safe from subsequent attack.

If the infection occurs during pregnancy, and there is doubt about her antibody state, a check with the H.A.I. test may be made at once. It is then repeated two to three weeks later. If there is a sudden subsequent rise in "titre," then it is presumptive evidence that rubella infection has occurred, and the risks can be outlined to the patient, and the correct advice offered to her.

(2) *Cytomegalovirus Infections (CMV).*

Infection with this virus is common among adults, and it often passes unrecognised. However, should a pregnant woman become infected for the first time, the virus readily passes the placental barriers into the developing embryo. Here, serious consequences can occur. In fact, in many cases it causes the death of the developing infant. But in instances where it survives, severe neo-natal illness invariably follows.

The liver is affected, and jaundice can occur to a severe degree. But the most important defect is in the brain. The virus is responsible for serious neurological complications which frequently result in mental retardation. In fact, about 10 per cent of the cases of mental retardation in the United Kingdom are allegedly due to CMV infections before birth. At best, treatment is poor, and the outlook for babies affected before birth is grave.

(3) *Other Viral Infections.* Since the recognition of these two well-established viral foes to developing infants, a large amount of investigation has been carried out with other common forms of viral infection.

Although the evidence is not so concrete, it seems that almost any viral infection during early pregnancy may, in some cases, produce developmental problems. The common cold, due to an ever-changing number of related viruses, and various forms of influenza, have also been incriminated.

No doubt time and more research will give a clearer picture of their virulence and danger in the pregnancy picture.

Poliomyelitis is fortunately a disease that has almost vanished from the scene of Western medicine. But sporadic cases are still reported. It is worth noting that pregnant women are quite prone to this very disabling disease, and the risks of paralysis, it seems, are more likely in the early stages of the disease.

Therefore, women who have not received immunisation against polio are advised to have this carried out. This is even more important if they intend travelling in the near future to a country where polio is still rampant, and there are many countries in the world where this is the case.

(4) *Bacterial Infections.* Two other infections are worthy of mention. These are both venereal in nature, and are represented by gonorrhoea and syphilis. Both may have an adverse effect on the developing embryo, as well as having serious repercussions on the parent if left untreated.

Both diseases are produced by bacteria. Therefore, they are much more amenable to treatment. Massive doses of currently used antibiotics can quickly destroy the bacteria before they can do much harm to the embryo, provided therapy is instituted promptly.

However, there must be a history of sexual contact (presumably with an infected partner) before these diseases can be contracted. Both diseases have been fairly quiet until very recent times, when both have shown a marked upsurge in activity. It is now well recognised that promiscuous living and a variety of sexual partners constitute the most common way of contracting either or both of these diseases.

DRUGS MAY BE DANGEROUS

In the early 1960s, the first warning shots that certain drugs administered during early pregnancy might be dangerous were fired by an Australian obstetrician named William McBride.

It was reported in London's medical magazine *Lancet* in the form of a short letter in the correspondence pages. Of course, what transpired is now well-established, world-wide medical history.

It was the start of the thalidomide disaster revelation. This drug had been prescribed with good intent by physicians around the world as a safe and reliable sedative. But given to pregnant women during the early months, it proved to be a monster in disguise. It had a profound effect on

Downloaded from Fountain of Knowledge Library

the development of certain key parts of the body, and subsequently great numbers of deformed and crippled children were born.

Since the tragic sixties, an enormous amount of research has been pumped into the study of drug therapy during pregnancy. The results have been so startling that now there is a blanket procedure followed by most obstetricians throughout the Western world. It is simple, clear and straightforward. In essence it merely says: "No drugs of any description during pregnancy."

In practice it is modified a little. The risk is highest during the early months of pregnancy (particularly the first four.) So, doctors are loath to recommend any form of drug therapy during these first few vital months when cells are dividing and vital organs are being formed.

Perhaps the only forms of medication to escape this blanket edict are simple preparations such as iron, which is often required by the pregnant woman.

Many doctors order vitamin preparation, and I believe this is a good idea. Much misinformation has been printed about vitamins over the past few years, but there also seems a lot of evidence supporting their value, both for normal healthy people as well as for pregnant women. I think they have a lot going for them. Most are water-soluble, and any unwanted excess will be excreted. We gain enough vitamin D from the sunlight, and probably receive sufficient vitamin A from our food—A and D are the ones which may cause trouble if used in excessive amounts.

Some women may have heard of medication called Debendox, which was used for many years to check the nausea of pregnancy. In 1982 this was removed from prescribing lists and its manufacture ceased. Public pressure was against the medication, although for many years, thousands of women took it with good results, and with no ill effects either to themselves or their baby. Today, many doctors are swinging back to simple old vitamin B_6, also known as pyridoxine, to check nausea.

But as for other forms of medication, doctors say, "Hands off—leave them all alone!" This extends even to simple everyday over-the-pharmacy-counter lines such as aspirin products.

So, any pregnant woman is well advised NOT to take any form of medication under any circumstances, particularly during the first three or four months of pregnancy. Be guided absolutely by your doctor's recommendations. And do not forget that this includes any of the

Downloaded from Fountain of Knowledge Library

readily available products you might not place in the category of drug therapy. Think twice before you place anything in your mouth when you are pregnant! This could be the only way to guarantee complete safety.

The Contraceptive Pill and Hormone Products. In very recent times, more and more attention is being given to congenital abnormalities and to the possible causes.

With increasing frequency, added pieces of well-documented evidence come from leading research hospitals in various parts of the world. Collectively, these make interesting and thought-provoking reading.

It has become apparent that the use of hormonal products in early pregnancy could be a consistent and important cause of many congenital deformities. Such may be taken by an unsuspecting mother in a variety of ways.

The most likely is to continue taking the contraceptive pill even though pregnancy has occurred. Although pregnancy is most unlikely when taking the Pill strictly as prescribed, various situations can arise where it is inadvertently missed. Or the patient may suffer from a gastric upset for a few days, and unwittingly vomit the Pill. Protection lapses, and pregnancy may subsequently develop. The Pill may be continued with the woman unaware of a pregnancy developing in her womb.

Although at present the evidence is still fairly sparse, enough documentation is on record that indicates this may produce developmental problems. So, pregnancy and the Pill seem to be definitely not recommended.

Another potentially serious cause of trouble in the same field is the use of hormonal products for performing pregnancy tests.

Before the widespread availability of the immuno-chemical pregnancy tests (which test the urine or blood for the presence of H.C.G.), hormones were used as a common method of checking.

This was administered in the form of injections or tablets. If the patient bled after the hormones, it was presumptive evidence she was not pregnant. But if bleeding did not eventuate, it was highly probable she was pregnant.

These tests were in use for many years, and were considered to be safe from producing congenital abnormalities. But evidence began to accumulate that this was not always the case. Now a substantial amount of evidence indicts the use of these hormonal products. In Australia they have been banned by the governmental authorities, and their use has virtually stopped. Similar precautions will no doubt be taken in other countries also, and it is highly probable this has already occurred by now.

Certain other hormonal products have also been incriminated. Progesterone, which was once given to mothers who showed a tendency to miscarry, has been incriminated as producing abnormalities in the developing infant. It is now no longer recommended for these purposes.

Another serious problem which has come to recognition only in the past few years is the long-term effect of certain hormonal preparations given to mothers during pregnancy. It seems that quite a few women were treated with the hormone stilboestrol. Although their babies appeared to be normal, many cases of vaginal cancer have subsequently been reported in their female offspring, several years later.

Medication for Epileptics. Many reports have been issued on the relationship between drug medication taken by patients under regular treatment for epilepsy, and congenital birth defects.

The treatment of epilepsy is a continual, ongoing process. But from studies carried out in many countries, including one at the Royal Women's Hospital in Melbourne, it now seems there is a definite and fairly high risk in becoming pregnant while on this form of therapy.

This naturally raises a problem of some magnitude in the minds of younger women recently married who are desirous of having a family. Should they cease their medication, reproduce and run the risk of epileptic attacks? Or should they run another risk of producing abnormal offspring, and remain attack-free?

It is a question of major importance in their lives. At present there is no simple answer. With the passage of time, the question will become more difficult to answer. They must discuss the whole situation with their obstetrician before ceasing medication or embarking on a course that will result in pregnancy.

X-RAYS—BEWARE!

The final topic to be discussed in this section is that of X-rays. Thirty years ago, it was almost routine for pregnant women to have a radiological procedure called "pelvimetry" carried out.

This was aimed at measuring the bony outlet of the pelvis, and assessing if there was adequate room for the baby to pass freely through during labour and the delivery.

Downloaded from Fountain of Knowledge Library

However, in recent years, the full force of the power of X-rays on rapidly dividing foetal cells has become more apparent.

Radiation damage, and the possible development of genetic mutants is universally recognised. Therefore, the wild enthusiasm for radiography has come to an abrupt full-stop during pregnancy.

Now, every effort is made to protect women from the possible hazards. In fact, in many major hospitals, X-rays of the pelvis or abdominal areas will be carried out only when it is known for certain that pregnancy does not exist.

Considerable efforts are made to this end. In some instances, X-rays during pregnancy may be essential. Under these circumstances, special precautions are available for the mother and infant who are at special risk. The practical application of this lies in a pregnant women inadvertently subjecting herself to X-ray doses without thought.

In many areas, mass radiography is still carried out. It is wise to consider this if you are invited to attend for these purposes, or to embark on any mass screening system. As one obstetrics expert recently wrote: "No female who might be pregnant should ever undergo any pelvic radiological investigation in the second half of the menstrual cycle."

Awareness Important

The reason for the inclusion of this chapter is not to instil fear, but to advise. So many heartaches and heartbreaks have occurred in recent years that the position has suddenly assumed major magnitude in the lives of many, and in the minds of many more, doctors included.

Without knowledge, a great many errors are made regularly. With increasing knowledge, the chances of reducing these errors increase also. Fewer errors mean fewer disasters. In turn, this yields fewer dilemma situations and sorrowful incidents.

Everybody loves to see a new life develop and be born. But nobody rejoices when that life is marred by some unfortunate, ugly deformity. There are no laurels for martyrs these days. Having a major defect at birth, or even worse, of developing one some years later for reasons entirely out of one's control, but due to influences occurring before birth, is an even more difficult plight to contend with.

Current knowledge allows many of these problems to be stopped before they occur. Care in medication, care if certain diseases are contacted or contracted, sticking implicitly to medical advice, all play a valuable part.

It is imperative that every prospective mother (and father too, for that matter) at least be aware of the potential hazards in the world of today. They are many. But equally, many can be avoided by sound common sense.

Please read this advice, try to remember it, and at least be practical about it. It could make someone's future so much brighter.

Downloaded from Fountain of Knowledge Library

Chapter Six:

Watch Your Weight When You Are Pregnant

Weight gain during pregnancy is normal and inevitable. But sticking to simple, commonsense principles will avoid unnecessary overweight which can be both dangerous and a problem afterwards.

Watch your weight when you are pregnant!

These days, women are more weight-conscious than ever before. This is because weight is related directly to physical appearance, and the "figure." In Western society, a "good figure" is equated with physical attraction and feminity. Many women find the temptation of excessive eating too hard to resist, so they become overweight.

As the mirror stares back and reproaches them, the majority realise their folly, but usually after it is too late.

Overweight is recognised as a national emblem of an affluent society. The more money there is to spend, the more people eat (both men and women). But this is poor solace when a woman is suddenly stripped of her attractive appearance, and becomes part of the forlorn race whose looks have ceased to be.

However, an alteration in figure during pregnancy is unavoidable. It is part of the physiology of reproducing, and this aspect of a woman's life is accepted and acceptable. It is a self-limiting situation, and usually merely a matter of time before most women are able to regain their former silhouette. However, as many women who have previously reproduced know so well, there are many hazards encountered during pregnancy, as far as avoirdupois is concerned.

A gain in weight and alteration in shape there will assuredly be. But it is very easy to let this merge into unacceptable weight gain. If this occurs, when the pregnancy is over, it may be very difficult to slip back to the pre-pregnant weight or figure.

So, for purely "social" reasons, women should take a second look at the weight factor during their days of pregnancy.

As a general rule, the total weight gain during pregnancy should not be in excess of 33 lb (15 kg). Women are well advised to gain no more than 1 lb (0.5 kg) a week during the last twenty weeks of pregnancy.

When these limits are exceeded, the risks of permanent weight increase are very high. Every woman knows the difficulty in reducing. After the birth of a baby, it can be even more difficult, so that many women slip silently into a permanent increased weight, complete with its potential hazards, socially and medically.

During pregnancy, weight increase is also important, as it may be related to serious complications. One of the most important is a condition called pre-eclampsia. If this takes place, it may lead to even more dangerous

Downloaded from Fountain of Knowledge Library

complications which may eventually be a problem to the woman and her baby. (This is discussed more fully in the chapter entitled: "Things That Can Go Wrong and How They Are Corrected." Turn to this if you desire further information on this very important subject.)

The mother gains weight for many reasons. There are two main components which are worth considering.

(1) *The Foetal Components*. These include the foetus itself, together with the placenta (later to become the afterbirth), and the fluid in which the baby develops, called the "Liquor amnii."

(2) *The Maternal Components*. These include the womb (uterus) and breasts; the increased

Downloaded from Fountain of Knowledge Library

amount of blood present; the storage of fat and protein by the body, and storage of water.

(1) *The foetal components*. As every mother knows, the weight of new-born babies varies considerably. Besides differing in babies born in the same country, there is also quite a difference from nation to nation.

In Australia, the average birth weight of babies is 3,300 g (7½ lbs). But in India, the average birth weight is 2,900 g (6½ lbs). Both may be equally fit and healthy.

The age of the mother has no bearing on baby's weight, but there is a tendency for the weight to increase with subsequent babies born to the same mother. The more affluent the living standard, as a rough rule, the heavier the baby tends to be.

A well-established cause for below-average birth-weight babies is smoking by the mother during pregnancy. Indeed, this has now become such a vital problem in Western lands that mothers-to-be are definitely advised to cease smoking totally during pregnancy. Underweight (and premature) babies run many risks not shared by their normal-weighted counterparts.

In the early stages, and up to the twentieth week, the foetus gains weight very slowly. But after this, a steady increase takes place.

The placenta (afterbirth), the vital link between baby and mother, is a large meaty organ. In the early stages it grows rapidly up until the sixteenth week. After that its rate of growth slows down, so that by birth, it weighs about 20 per cent of baby's weight.

The "liquor amnii," the fluid contained in the womb, and which bathes baby throughout uterine life, is a major weight-producing factor. Its volume increases quickly throughout pregnancy. There are 300 ml at twenty weeks, 600 ml at thirty weeks, and around 1,000 ml at the thirty-eight-week mark. After this it falls rapidly.

(2) *The Maternal Components*. The womb (uterus) quickly increases in weight during the early weeks of pregnancy, especially the first twenty. After this it increases more slowly up until the fortieth week. By the time baby is ready to be born, it weighs about 900 g more than its non-pregnant weight.

The breasts develop rapidly right from the start, under the influence of special hormones. The breasts are prepared for the day baby is born and they will provide its nourishment. A large increase in the total amount of blood in the system also occurs during pregnancy. This, too, adds to the overall weight increase.

A lot of weight increase is due to the storage of fat by the pregnant woman. In fact, an average of about 4,000 g is usual. Most of this is laid down before the thirtieth week. Most of this comes from carbohydrates and fat in the diet, and a small amount comes from the extra protein eaten.

There is a very real reason for this extra fat. It has been shown that nearly 35,000 calories of energy can be obtained from these deposits if suddenly required by the mother in the weeks immediately following baby's birth. In short, she is geared to perform more work. But a note of caution should be inserted here: this should not be used as an excuse to deliberately put on more weight. As shown earlier, excessive weight gains during pregnancy predispose to a permanent overweight problem after pregnancy. This may continue for a long, long time.

After the thirtieth week, the main reason for weight gain is the retention of water by the body. For the first thirty weeks, she will retain 3,600 ml, plus a further 3,000 ml between then and the time of birth.

Excessive weight gain must be eyed cautiously in the last ten weeks. Regular weighing is essential. If there is a gain of more than 900 g (2 lb) in any one week, it indicates excessive fluid retention, and may be an early sign of pre-eclampsia, a serious complication of pregnancy.

There is no need to be alarmed at all this discussion on excessive weight gain. Basically, it is quite straightforward and relatively simple.

The basics are that an increase in weight during pregnancy is normal and natural. Excessive gains are to be avoided, and this can simply be done by a commonsense routine that avoids the type of foods that should be avoided in any case during normal (non-pregnant) life.

There is the added precaution that any excessive weight gain needs immediate investigation, especially in the latter ten weeks of pregnancy. By sticking to sensible general principles, most women will come through their confinement and soon regain their former attractive appearance.

There is absolutely no need for a woman to "go to seed" during pregnancy. So often it is blamed for an unattractive figure later on, when, in fact, the true reason lay in foolish indiscretions and a lack of attention to simple detail by the woman herself.

It is really in your hands. Do not forget this.

Downloaded from Fountain of Knowledge Library

Chapter Seven:

Sensible Eating Pays Off

Stick to a commonsense eating routine, and pregnancy will hold fewer problems. Avoid fancy fad routines. Adhere to proven basic principles.

What should the pregnant mother eat?

Much has been written and spoken about this. A tremendous volume of ridiculous advice has been offered, and no doubt will continue to be offered. For some strange reason, the pregnant woman has always been the target of all kinds of well-meant advice given her by everyone who thinks that their information is "special."

Of course, as so many mothers-to-be are young, and without yardsticks with which to compare, they are vulnerable to the verbal missiles of every so-called expert in the land.

Pregnant women are a fine target for commerce, too. Not only is their own health involved, but they are responsible for that of their developing offspring. For this reason, many feel a moral obligation to seek out the very best, and cost what it may, give this to baby-to-be. So the advertising experts aim their propaganda at the unfortunate expectant mother.

Give baby this; take that; eat something else; regularly imbibe this vitamin compound, or else you are depriving your poor little baby of the "best." So the story goes on and on. Every day mothers across the land are bombarded with slick advertising and dubious promotion, essentially in the name of commerce, but dished up so that it appears to be in the name of better health, life and vitality for mother and baby.

As a general rule, pregnant women would be far better off completely ignoring this barrage of "advice." It is far better to stick to simple, well-established principles as far as dietetic intake is concerned. Ignore the fad routine so often advised. Ignore the smart advertising and glossy folders from pharmaceutical houses.

Many of these firms certainly give advice, much of which is reasonable, but they are essentially out to separate you from your money.

The baby business is big business in every country in the Western world. So, read the mass of material that is thrown your way. But treat it all with a rather critical eye.

Your doctor will outline the general principles that matter. Use these as the basis for your food patterns. Don't be duped into spending a fortune on fancy products. Neither you nor your baby will measurably benefit.

In general terms, a pregnant woman will eat much the same type of food she ate before she became pregnant. It will not change much. The old notion that she "must eat for two" is an idea of a bygone era. There is quite sufficient in her normal daily food intake to take care of herself plus the needs of her growing infant, provided she is careful and sensible in her food selection.

Downloaded from Fountain of Knowledge Library

A person's normal food intake varies. It will depend on the country in which she lives, and the local cultural habits. It is related to her normal routine, and this in turn is related to her socio-economic standard.

When money is no object, families tend to consume more protein products, as they are usually more expensive, and perhaps more desirable. Poorer people tend to eat more carbohydrate (starchy) products.

Recently a well-known obstetrician succinctly summed it up this way: "In affluent societies the advice should be, Buy all you can afford from the butcher, the greengrocer and the dairy, and spend only little at the confectioner's, the grocer's and the chemist's."

This is an excellent precis of what is best for the pregnant woman. It may be used as a constant guide throughout the full term of her prenatal months.

These days, there is an increasing emphasis on the value of a vegetarian dietetic routine, not only for pregnant women, but for the community in general. It is now well established that meat substitutes are perfectly safe, and quite adequate. So, women desiring to follow a vegetarian diet can certainly omit meat products. However, it is essential that this be replaced by adequate amounts of protein replacement items.

Many protein replacement foods are easy to make, and frequently involve the use of soy beans, soy products, gluten flour and the many items that are readily prepared from these, and many other bean products. These include Lima, broad, butter, navy and other bean varieties. Most nuts are high in protein values, and these include cashews, almonds, peanuts, etc.

Today, many of these items are available ready for use, and precooked in commercial form (tinned). As a flow-on from this, a wide range of "health food" products incorporating the use of most of these products is now widely available commercially. So, for those desiring this excellent form of protein intake, there is no shortage of products from which to choose.

For women not conversant with vegetarian eating and cooking, today there are plenty of recipe books which clearly set out methods of preparing nutritious and attractive meals, using these non-meat products.

A more accurate break-down of the essential items the pregnant woman requires in the way of vitamins and other essentials is given below.

Daily Requirements

The recommended "Daily Allowance" of

It is an old wives' tale that a pregnant woman should "eat for two."

Downloaded from Fountain of Knowledge Library

nutrients for the average pregnant woman (from the twentieth week on).

	Kilojoules 10,500 (2,500 Calories)
Thiamine	1.0 mg
Protein	65 g
Riboflavin	1.5 mg
Calcium	1,000 mgm
Nicotinic Acid	15.0 mg
Iron	15 mg
Ascorbic Acid	50.0 mg
Vitamin A	6,000 u
Folic Acid	1.0 mg
Vitamin D	4,000 u

This may all sound a bit theoretical. But, when this is translated into understandable words, it simply means that the following foods should be included in the diet each day:

One pint (.6 litres) of fresh milk. (This may be taken raw, or made up in drinks, puddings, custards, or in the form of cheese.)

60 g (2 oz) of fish or meat (or protein substitute) and one egg daily.

One orange, one apple or a slice of pawpaw (papaya).

Green, leafy vegetables at least three times a week.

Apart from this simple routine, she may eat whatever she likes! However, a careful watch must be kept on the weight, for this is important during pregnancy. Sudden weight increases can lead to a serious complication in pregnancy called pre-eclampsia.

The majority of women will also benefit from the regular intake of an iron tablet daily. The actual amount will vary according to the results of the blood tests arranged by the doctor at your early visit to him.

Some women who live under poor social and economic circumstances, and women in the less affluent, developing countries may require additional vitamin and mineral needs if their diet is deficient. Such people would benefit from an iron tablet three times a day, and a vitamin tablet containing ascorbic acid 50 mg, folic acid 1 mg, thiamine 2 mg, riboflavin 2 mg, and nicotinic acid 15 mg.

Vitamin Names. Many women become confused at the seeming profusion of vitamin names. The most commonly talked about group of vitamins are those composing the "Vitamin B Complex." This consists of a series of components, and there are several synonyms.

Vitamin B_1 is also known as Aneurin or Thiamin.

Vitamin B_2 is also known as Riboflavin.

Vitamin B_6 is also known as Pyridoxin.

Nicotinamide and Pantothenic acid belong to the complex also.

Vitamin B_{12} is also known as Cyanocobalamin.

The other commonly used multiple name vitamin is Vitamin C, which is also known as Ascorbic acid.

Downloaded from Fountain of Knowledge Library

Chapter Eight:

Annoying Problems that Occur During Pregnancy

Several troublesome symptoms may arise during pregnancy. Few are serious or debilitating. Most have a simple explanation, and relief is often readily available with simple measures.

For most women, the days of pregnancy are happy and relatively free from discomfort and trouble. However, it is inevitable that a few abnormalities occur from time to time. After all, major changes are taking place in the lower pelvic area. A rapidly growing mass is developing there, and with the passage of time, gradually pushes up into the abdominal region. When this happens, organs are forced to move to make way. In addition, certain unusual pressures and stresses are produced.

Besides this, the massive production of extra chemicals by the pelvic organs often has a profound effect on the entire system. Although women automatically adjust to these altered circumstances in a very remarkable manner, some produce symptoms which tend to cause them some worry. The majority are self-limiting, and are cured without interference. But some suggestions can assist in alleviating other symptoms.

Here are the main symptoms that may produce some temporary discomfort, together with some recommendations as to how they can be overcome.

HEARTBURN

The small valve at the lower end of the food passage (the oesophagus) leading to the stomach tends to become lax. For this reason acids from the stomach can readily regurgitate or "reflux" into the lower end of the oesophagus.

This produces a burning sensation commonly referred to as heartburn. It is merely a name, and has nothing to do with the heart muscle itself. It has no sinister connotation, and is not indicative of disease.

A sensible approach to eating often brings relief. Avoiding stimulants can do much to help. Ceasing the intake of spices, condiments, sauces and pickles, and reducing the intake of strong tea or coffee will minimise the problem. Small, frequent meals of a bland, non-stimulating nature assist. An increase in the intake of milk and milk products is often useful.

Sometimes the use of antacid mixtures and tablets can bring relief if distress is severe. Alginic acid compound in the form of granules seems to assist some. These are innocuous preparations.

Extra pillows permitting sleep in a semi-

Downloaded from Fountain of Knowledge Library

upright position help to keep the acid in the stomach where it belongs. Some have found placing a brick under the head of the bed (producing a similar sleeping position) a good idea. However, others find this uncomfortable, and there is a tendency to slip down toward the foot of the bed. (Husbands often complain loudly and most bitterly about this!)

CONSTIPATION

Constipation is common during pregnancy, particularly in the latter stages. The intestinal system has a lowered "tone," and tends to become lax. Later on, the added pressure of the large womb also aggravates the situation.

An increased fluid intake helps (preferably by the use of fruit juices or plain water, not increased amounts of tea, coffee or sugary aerated beverages or alcohol-laced drinks).

Endeavour to re-establish normal bowel movements. The usual time for these is after a meal. Set a time each day, say after breakfast, and concentrate on this, and results are often successful.

In recent times the increasing value of adding bulk to the bowel has become well recognised. Adding one to three tablespoonsful of simple unprocessed bran to the food at each meal can produce excellent results. Bran absorbs fluid. This increases bowel bulk, and greatly reduces "transit time," the length of time material stays in the bowel.

Bran can conveniently be taken with other foods high in natural fibre. Breakfast foods such as muesli may have bran added. It is also a good idea to add chopped-up dates, dried figs, sultanas and raisins. Add a little milk, or water, and honey if desired.

Muesli is composed of natural grains. The total picture is a meal of relatively high nutritional value. At the same time, it is almost a written guarantee of normal bowel actions.

Using this simple system, the need for laxatives and cleansing enemas—the alternative—is usually quite unnecessary.

HEADACHES, PALPITATIONS AND FAINTING

The fainting heroine (who also happened to be pregnant) has been the cliché of thousands of old-time novels and movies. (The other one used and reused with monotonous regularity was the doctor delivering the baby at home. He needed buckets and buckets and more buckets of boiling water. Generations of modern-day doctors are still asking what he did with all that boiling water!)

However, as many pregnant women know so well, it is not uncommon to develop sensations of feeling faint. Or there may be recurring bouts of head pain, often mild, and seldom really severe. An awareness of the heart beating in the chest, with or without actual exercise is also quite common.

None of these symptoms is serious. Indeed, they may occur to a certain extent in most pregnant women. It is merely due to the altered nature of the body's blood reservoirs.

With the advent of the pregnant womb, a large amount of blood is transferred from the usual body circulation to the pelvic regions where it is needed to succour the new, developing life.

For this reason, these other circulatory abnormalities tend to take place.

The symptoms are not serious. They are not dangerous. They do not indicate any sinister disease process. They are entirely self-limiting, and will phase out automatically in due course.

VARICOSE VEINS

The development of prominent blood-vessels, particularly in the lower limbs, is common during pregnancy. Indeed, very few women manage to escape this to some degree. In some cases it is very marked, and unfortunately these may persist after the confinement.

Frequently the limbs will ache, and the more prominent the veins, the greater the discomfort. They are aggravated by long hours of standing, especially on hard surfaces such as concrete floors. Many women who continue working during pregnancy and have to stand all day may find the complaint quite distressing.

Varicose veins are often an inherited factor, so if your parents had them severely, then you are most probably headed in a similar direction.

They are produced by the increasing mass in the pelvis pressing on the great veins as they return blood from the lower limbs. With the increased stress, the valves in the vessels that help the return of blood frequently break down, and this often produces lumpy nodules so characteristic of varicose vessels.

Much can be done to assist, however. Keeping off hard surfaces for prolonged periods of time is important.

Wearing elasticised stockings can often be very helpful. Special maternity fashions are available in many areas which provide both for this type of hosiery, as well as adequate room for

Downloaded from Fountain of Knowledge Library

the expanding abdomen. They are highly successful.

Whenever possible, keep the lower limbs elevated, preferably at a level equal to or higher than the hips. This assists the blood flow back to the body with the help of gravity. Some women find it helpful to lie on their backs on the floor and place their limbs at right angles to their body up against the wall. This has a similar mechanical beneficial effect. It can add greatly to personal comfort. Simple massaging of the limbs, using a soft, sweeping movement from the feet upwards, can also help.

Sometimes doctors may inject some of the more prominent veins, but this is best left until after the confinement. Many vessels will disappear at this time, and then the most persistent problems may be dealt with. But other doctors feel that varicose veins should not be tampered with until after the reproductive days are over permanently.

HAEMORRHOIDS (Piles)

Many women are troubled by haemorrhoids (or piles). This is often worse in the later stages of pregnancy, and during actual labour. These are an extension of the varicose vein problem, and are actually distended veins in the lower part of the bowel. In some women they are very prominent and quite uncomfortable.

Eliminating constipation can often assist in a remarkable manner. Having unprocessed bran, ideally with muesli, for breakfast each day is good and effective therapy. Often, through the application of simple creams such as lanoline, a soothing result can be obtained. Sometimes clothing rubbing against the piles (which may prolapse) can be very uncomfortable, and local applications can reduce this. Sometimes the insertion of suppositories can assist in shrinking them.

But piles are essentially a mechanical problem, and nearly always they rectify themselves automatically when the confinement is over.

EXCESSIVE URINATION

In early pregnancy, the kidneys tend to produce more fluid than usual. This results in the desire to urinate far more often than normal. Indeed, so common is this symptom that it is often regarded as one of the early tell-tale symptoms of pregnancy.

Toward the end of the term, as the foetal head presses on the bladder, frequency is again quite common. This time it is a mechanical cause.

Both types of frequency are non-serious. They do not indicate disease and, apart from the transient nuisance factor, should be ignored.

Women are more prone to urinary-tract infections during pregnancy. This is often accompanied by the passage of unpleasant-smelling urine, aches and pains and possibly an elevated temperature. The fluid may contain blood, or be cloudy. The desire to pass the urine often occurs, and it is often accompanied by a burning sensation, and the desire to micturate again soon after. There is a lack of comfort, even though the bladder has been emptied.

It is important that urinary-tract infections be dealt with adequately, and medication may be necessary. Often a fever and pains over the bladder or in the back may accompany the other symptoms.

Tests may be carried out by the doctor to determine if infections are present. They will also indicate to him the best form of therapy for your particular infection.

DROWSINESS AND BECOMING PLACID

Many women find they feel very placid, and even drowsy during pregnancy. Some may find fatigue is often quite overpowering, and they feel the need for more sleep.

Many of these cases are due to the side-effects of the increased circulation of the hormones of pregnancy. Progesterone can yield this sensation. It is all part of the normal process of pregnancy, and is nothing to worry about.

Excessive fatigue may be accentuated by a reduction in the haemoglobin, the red material of the red blood cells. Indeed, many women have reduced levels during pregnancy, and one of the effects of this is a lack of energy and increased fatigue factor.

This is one reason why the doctor carries out blood tests early in pregnancy. The haemoglobin level is measured. If it is reduced, then iron preparations may be prescribed. This tends to elevate the levels back to normal once again.

BACKACHE

Many women are troubled by backache, especially in the latter months of pregnancy. The sacro-iliac joints are the ones to be affected most, and their ligaments tend to become looser and more supple. These are the joints at the lower end of the back, where the spine fuses with the pelvic girdle.

With advancing pregnancy, the centre of balance of the body alters. To compensate for this, the woman tends to throw her shoulders

Downloaded from Fountain of Knowledge Library

back. This adds to the strain in the lower back, so precipitating discomfort and a constant, nagging strain.

Common sense in footwear is essential. Avoiding high-heel shoes whenever possible is advised. Keeping the entire back as straight as possible, rather than just the upper parts will also assist. These simple points will give a considerable amount of assistance with the progression of time. If they are commenced early in pregnancy, they will be carried out automatically as the situation worsens with the advancement of the pregnancy.

Some other women find that the ligaments of the other pelvic joints (notably in the front where the pubic bones unite) relax abnormally. The bones tend to move on each other. This produces pain and discomfort.

The best advice here is to go to bed for a few days and lie on one side or the other. A firm binder around the pelvis may assist.

LEG CRAMPS

Very uncomfortable cramps in the lower limbs are common, and this may take place during the latter stages of pregnancy. The cause is unknown, and treatment is not very satisfactory.

Often the use of calcium lactate tablets, either 2 g at bedtime, or 2 x 300 mgm tablets with each meal, can yield considerable relief.

Massaging may help sometimes. Others find that keeping the bedclothes off the limbs by various ingenious methods can produce a marked reduction in discomfort. By making up a cube measuring about 30 cm in all dimensions (approximately 12 inches), and placing this between the lower limbs at the lower part of the bed, the bed clothing can be arranged so that it does not press on the limbs. It is a simple measure and the advocates claim it is worth the small amount of effort involved. At least it is worth a try if this is your problem.

Some women find that an increase in the milk intake also increases their calcium intake, and this can also assist.

SLEEPLESSNESS

During the latter stages of pregnancy, many women find the summation of their problems a little overwhelming. There may be leg cramps and discomfort in the back. The added mass in the abdomen limits the positions in which they can sleep. Often insomnia gains a foothold.

Some doctors prescribe mild sedatives to be taken from time to time. There is an increasing swing away from the use of regular sedatives at night. But for a short time, if they are the only way of gaining a good night's repose, then they will do little harm.

But simple measures such as a hot glass of milk, or a malt-based drink will often have a mildly sedating effect also. It is worth a trial. It is best to avoid tea and coffee at night, for the caffeine content tends to have a stimulating effect, the reverse of what is being sought.

SWELLING OF THE FEET

This is technically known as oedema. It is common during pregnancy, due to the increased pressure in the blood-vessels of the lower limbs, together with their distension brought about by circulating hormones. It is worsened in hot weather, and long hours spent in the upright position.

The treatment is similar to that for varicose veins.

However, the sudden onset of ankle oedema, especially in conjunction with elevated blood pressure and protein in the urine, may be a serious sign. It could indicate the onset of the pregnancy complication called pre-eclampsia. So if you suddenly awaken with swollen ankles, report it to the doctor promptly.

PERSPIRING AND FEELING HOT

The circulating hormones often cause the blood-vessels in the skin to dilate. Thus a feeling of heat, and sweating more than usual is common, especially in the latter months of pregnancy. Hot days will aggravate it.

Drinking more fluid, trying to keep cool, reducing physical activity, taking more rest periods, having frequent cooling baths and showers can often give symptomatic relief.

DARK SKIN

Many women notice dark blotchy areas appear on the skin, and this may occur from an early date in pregnancy. Once more this is a side-effect of circulating hormones. The area surrounding the nipples and the nipple itself will become darker in colour.

It is usually more apparent in normally dark complexioned people and those with a normal olive-type skin. Exposure to the sun tends to aggravate it.

The forehead, cheeks and neck are frequently special at-risk areas. Scars, and the midline area of the abdomen also seem to have a predilection for this pigmentation.

Generally, when the confinement is over and the hormonal levels revert to normal, many of

Downloaded from Fountain of Knowledge Library

these areas wane and disappear altogether. In some areas it persists, especially in the areola, the nipples, scars and the abdominal midline parts.

Women on the contraceptive pill (which contains similar types of hormones) often notice these dark markings. They are referred to as chloasma. A preparation called phiaquine creme is sometimes used with beneficial results in the more obvious parts. It is applied locally.

VOMITING

About 50 per cent of women experience nausea and possibly vomiting in the early stages of pregnancy. It often starts around the sixth week, and usually ceases by the twelfth week. In 45 per cent of cases it is mild; in 5 per cent of cases it is moderate, and only in about two cases in 1,000 does it reach serious proportions.

It may occur in the morning after gastric secretions have accumulated in the stomach overnight. But it can also occur at any time of the day. Emotional and psychological factors play a large part once it has become established. Tensions and anxieties can aggravate it. Travelling will often make it seem worse. Often it makes the patient feel miserable and unhappy. She tends to go off her food, which in turn aggravates the situation.

Eating small, dry meals (up to six a day or even more) can often bring relief. Avoiding fatty foods and spicy meals is recommended. Fluids are best taken between meals. The use of glucose-containing beverages may assist. Glucose is well known for its nausea-allaying powers, and it is also a readily absorbed and utilised food in itself.

If symptoms are causing considerable discomfort, the doctor may prescribe medication, although the fewer drugs taken during early pregnancy the better. No drug should be taken unless under specific medical advice. Many women probably remember a drug called Debendox which often dramatically reduced nausea, but this was removed from the market in 1983. However, an old-timer called pyridoxine, or Vitamin B_6, nearly always successful, is now often used. It may be given as an injection by the doctor, and usually dramatically reduces nausea and vomiting. Being a natural vitamin it is perfectly harmless. Some doctors believe nausea is simply a symptom of a nutritional deficiency occurring during pregnancy, rather than an indication of any serious underlying pathology. Pyridoxine commonly produces a strange taste in the mouth, but doctors say this indicates that the body is receiving an adequate supply. It may be given with another member of the Vitamin B complex, aneurin, or Vitamin B_1.

A severe form of persistent vomiting is called *hyperemesis gravidarum*. This may need hospitalisation and more intensive medical measures. These cases are quite rare, averaging about two in each 1,000 pregnancies.

VAGINAL BLEEDING

Vaginal bleeding at any stage of the pregnancy must be regarded with extreme caution. The bleeding may be a dark brownish colour, or it may be bright red. Irrespective of its nature, report this at once to the doctor.

In the early stages of pregnancy, it may indicate that a miscarriage is imminent. Precautions may prevent this from occurring.

It may or may not be accompanied with pain.

In the latter part of pregnancy, any bleeding from the twenty-eighth week on must be regarded very seriously. It may indicate the presence of a condition called *placenta praevia*. Here the placenta (or afterbirth) is lying across the outlet from the womb. It may produce serious consequences, and it requires expert supervision from the moment it takes place.

A characteristic feature is that it is usually perfectly free from pain. Another condition called *accidental haemorrhage* may also occur later in pregnancy and bleeding is often the first sign of this too.

So, a cardinal rule is that any vaginal bleeding during pregnancy demands urgent attention from the doctor. Do not put it off. Do not delay. This may prove dangerous.

More will be said of abnormal vaginal bleeding in the chapter entitled "Things That Can Go Wrong and How They Are Corrected."

If troublesome symptoms flare up during your pregnancy, do not despair. It is worth trying the simple remedies first. Many of the symptoms have reasonable explanations and are self-limiting, disappearing in due course whether you are treated or not.

If the simple suggestions offered here are inadequate, then consult your doctor. He may offer further advice which will assist.

Generally speaking, there is no need to suffer in silence. Relief is often at hand, and it merely requires action on your part.

Sitting and fretting and fuming is a negative approach. This will make you miserable, and this escalates as you continue to feel more and more disconsolate. Action is the word.

Downloaded from Fountain of Knowledge Library

Chapter Nine:

Things that Can Go Wrong and How They Are Corrected

Many "complications" can occur during pregnancy. But early recognition and prompt attention will usually avert disaster. In this chapter, some of the more important problems are discussed, together with current therapy.

The average pregnancy will proceed with few problems until "term," and a normal, healthy baby will be delivered. Mother and baby will be fit and well. The family will share the delight.

However, while this is the usual picture, a certain number of abnormalities can take place. Some women appear to be at special risk, and are more prone to running into trouble than others.

Some of the more important complications that may take place during the course of pregnancy are outlined briefly. This is not done to frighten the mother-to-be; nor is it meant to deter anyone from falling pregnant. This chapter is written solely to let women know that things can sometimes go wrong.

It is important that these abnormalities be recognised. The earlier this takes place, the sooner suitable treatment can be started. The majority of these complaints are readily amenable to treatment.

Many of the so-called complications may be discovered only by the doctor during his routine regular examinations. This is one very important reason why these prenatal visits should not be neglected, for, maybe quite unbeknown to you, some sinister problem is starting to develop. The doctor may pick this up promptly, but if left, it may not become evident until trouble strikes in a much bigger way.

So consider these points. The important symptoms are set out. If you notice any of these starting to make their appearance, it is essential that you contact your doctor promptly.

ECTOPIC (OR TUBAL) PREGNANCY

This is a fairly rare event. It means that the fertilised egg fails to reach the womb on its journey from the ovary (from which it was released).

Instead, it settled at some part along the course of the Fallopian tube (sometimes called the oviduct). This odd occurrence seems more common in underdeveloped lands, where about one pregnancy in 150 ends up this way. In Western lands, the incidence is much lower, being about once in every 250 pregnancies.

The tubes are designed as pipes to transport the egg. They are certainly not meant to sustain foetal growth, and it is quite impossible for a pregnancy to continue there for any length of time.

So, symptoms of disaster are inevitable. It is merely a matter of time. Usually this is between the sixth and tenth weeks.

If the egg becomes implanted in the tube at the

Downloaded from Fountain of Knowledge Library

ovarian end, then a tubal abortion commonly occurs. This may be the least dramatic. The fertilised ovum simply dies, and is spontaneously aborted into the abdominal cavity.

If the egg is located more deeply along the tract of the tube, it increases in size, and gradually burrows into surrounding tissues. Often a major blood-vessel is finally eroded, and a sudden internal haemorrhage occurs. Blood may suddenly spread out into the pelvic cavity, often creating an emergency situation.

If this complication arises suddenly, and there is considerable blood loss, the patient will notice sudden severe pain in the lower abdominal area. Sudden collapse is common, and shock may occur due to the haemorrhaging. There may be some vaginal bleeding.

Urgent admisssion to hospital and medical attention is essential. With prompt diagnosis and surgical intervention results are usually satisfactory.

The key warning to any woman who appears to be in early pregnancy (one or two missed periods) is to seek prompt attention if there is any sudden onset of low abdominal pain. Call the doctor or get to a hospital.

In recent years, certain procedures have been claimed to increase the risk of tubal pregnancy. The use of the progestogen-only contraceptive pill (the so-called "mini-pill") had this charge levelled at it at one stage.

Operations aimed at reconstituting the patency of blocked Fallopian tubes were claimed to be followed by an increased risk of ectopics.

One ectopic seems to increase the risk of another if a further pregnancy takes place. (The risk rises to about 10 per cent.) Only about 60 per cent of women who have sustained an ectopic become pregnant again.

BLEEDING DURING PREGNANCY

Bleeding from the vagina at any time during pregnancy is a symptom that must be reported immediately to the doctor. In the early stages of pregnancy it could indicate an impending miscarriage.

But from the twenty-eighth week on, it could mean a serious complication which demands instant and expert medical care.

(1) *Placenta Praevia. Placenta praevia* means that the placenta (later to become the afterbirth at the confinement) is located low down in the womb. Usually it is high up in the upper part. But sometimes it settles in this abnormal situation. Problems can occur if any parts of the placenta encroach on the outlet from the womb.

This means that when labour commences and it is time for baby to be born, the placenta must come first. This, of course, is quite impossible, and serious haemorrhaging, jeopardising the life of both infant and mother, could result.

Therefore any bleeding occurring from the twenty-eighth week on must be regarded with care and suspicion. Usually there is *no* pain.

The doctor will admit you to hospital at once. If pregnancy is in the time segment between the twenty-eighth and thirty-sixth weeks, every effort will be made to let the pregnancy continue before any interference is made. This gives baby an improved chance of survival. Bed rest and medication is the regular method of treatment. Many cases settle down until the vital thirty-sixth or thirty-seventh week has been reached.

At this stage, the patient is taken to the theatre, given a general anaesthetic, and the pelvic area is examined. It is then frequently necessary to deliver the baby by means of a surgical operation called Caesarean section. This is through an incision in the lower part of the abdomen. The results of this operation are usually excellent, and it can be a life-saving measure for both mother and her baby. A blood transfusion is generally given, but recuperation afterwards is generally rapid.

(2) *Accidental Haemorrhage*. This occurs very occasionally, in about 2 per cent of pregnancies, compared with the frequency of *placenta praevia* which is around 1 per cent.

The placenta (afterbirth) is located in the normal situation. For reasons that are not clearly understood, the placenta starts to come away from its usually firm adhesion to the wall of the womb. As this happens, bleeding must occur. Some appears via the vagina as a haemorrhage.

The degree varies, and the treatment also varies accordingly. In mild cases, if the pregnancy has not advanced to the thirty-seventh week, hospital care is given and every effort made to let the pregnancy continue. Blood transfusions are given, and medication ordered according to the patient's condition.

When the thirty-seventh week has been reached and baby has a fair chance of surviving, labour may be induced, and a happy result is often the outcome. Sometimes, in more urgent cases, surgical intervention and a Caesarean section operation become essential.

Downloaded from Fountain of Knowledge Library

TOXAEMIAS OF PREGNANCY

This term covers three separate disorders which may occur during pregnancy, and which have a similar set of symptoms.

The actual names of the diseases are:

(a) Pre-eclampsia
(b) Essential hypertension (or raised blood pressure)
(c) Chronic nephritis (or kidney disease).

If these conditions are not treated, they may lead on to a further serious condition called eclampsia.

The possible occurrence of these disorders is another major reason why pregnant women must attend their doctor or clinic regularly for adequate prenatal assessments throughout the duration of pregnancy.

At these examinations, routine checks are made which almost always pick up the start of these complications. In this way, treatment can be commenced promptly. The serious disease of eclampsia may then be avoided, and mother and baby will come through the confinement satisfactorily.

The key triad of symptoms that the doctor seeks which could indicate the onset of these disorders include:

(a) *Rise in blood pressure*. The doctor likes to know your normal blood pressure, preferably before you became pregnant. He uses this as a base-line and compares subsequent readings against it. If there is a sudden rise in pressure, it is a definite warning signal. The higher the rise the more serious the situation.

(b) *Sudden weight gain*. A gain of more than 1.0 kg in any one week, or the appearance of swelling about the ankles (especially when rising in the morning) is suspect.

(c) *Protein material is found in the urine*. This is checked regularly each visit, and the presence of a protein called albumen indicates that there is potential danger.

Pre-eclampsia is more likely to occur in first-time mothers. It is said to be present if any two of the above-mentioned factors are present.

The onset of the disease is rare before the twenty-eighth week of pregnancy. It may be mild, or it may come on more suddenly and be severe. It complicates about 6 per cent of all pregnancies and about 12 per cent of women pregnant for the first time. Its cause is unknown.

Prompt medical care is essential, and the doctor will arrange this. Every effort is made to check the onward progress of the disease, to stop the next stage (called eclampsia) from taking

Downloaded from Fountain of Knowledge Library

place, and to get the infant to remain in the womb for the full term. This usually happens successfully, but quite often an "induction of labour" is necessary to bring on labour before it would occur normally.

Bed rest is given, and various forms of medication administered to reduce the fluid content of the body, and to bring the blood pressure down to normal levels.

Left untreated pre-eclampsia will probably advance to the condition called eclampsia, and this occurs in Australia and New Zealand in about one patient in 1,250 or even less. It is much more common in the underdeveloped countries. Drowsiness, dimness of vision and headache are the forerunners of convulsions and coma. This is serious, and demands prompt medical attention with the patient in hospital nursed by experienced staff.

This disease carries a high risk to both mother and baby. So once more, the importance of adequate preventive medicine in attending for prenatal checks cannot be too strongly emphasised. Most cases can be prevented or checked by this simple measure.

Patients with diagnosed elevated blood pressure and with kidney disease likewise need adequate treatment as soon as these conditions are diagnosed. Successful therapy is available, and this will be carried out under the doctor's supervision.

URINARY INFECTIONS

Infections which occur in the bladder, and which spread into the narrow tubes leading to the kidney (called the ureters) are common during pregnancy, particularly after the twentieth week.

Because of increased amounts of hormone in the bloodstream, the ureters tend to dilate, and this may encourage germs to travel from the bladder into the cavities of the kidney.

Due to changes occurring in the pelvis, complete emptying of the bladder is often difficult. Small amounts of urine are left, forming a reservoir for proliferating germs. Here they multiply rapidly. Frequently, no symptoms occur, and the infection simply smoulders on silently.

But when the germs commence moving into the ureters and on into the kidneys, symptoms can suddenly flare. Elevated temperatures, chills, fevers, aches in the lower back region, aches and pains all over, frequency of urination, the desire to empty the bladder a short time after this has already been done, with little satisfaction, all become commonplace symptoms. Vomiting and a high pulse-rate might also occur.

This demands prompt medical attention. The doctor will probably order a laboratory test on the urine. In this manner the organism producing the infection can be isolated, and the antibiotic to which it is most responsive determined. Treatment is usually commenced at once. Bed rest and lots of fluid are essential.

The results are usually satisfactory, and reduction in discomfort, temperature and the frequency of passing urine and a lessening of the scalding sensation take place rapidly. However, as reinfections are highly likely, continuation of treatment for the remainder of the pregnancy is often necessary.

Stick closely to the doctor's recommendations. Take the medication given exactly as prescribed. This is the quickest way to recover.

Although the use of medication during pregnancy has been discussed previously, when serious symptoms arise, it is often essential to embark on suitable medication. Any risks of this must be carefully weighed against the risks of the infections. The doctor will order medication with a careful eye on all aspects of risks.

However, many of the complications do not arise until the second half of pregnancy. By this time, the major risks have disappeared. The major cell multiplication and the development of each organ are long since complete, and for these reasons the risks of congenital malformations decrease.

IRON DEFICIENCY

As pregnancy advances, more and more demands are made upon the mother's reserves of iron. During the last twelve weeks a considerable amount of iron is transferred from the mother to the baby. It is essential that these depleted stores be made up to normal.

Even during normal non-pregnant life, women run a greater risk of having reduced stores of iron. Menstruation each month reduces the supply. Although a certain amount of this is made up during the subsequent month, it is very common for the level to be less than normal even early in pregnancy.

For this reason, the doctor usually orders a haemoglobin examination at an early date in pregnancy. The haemoglobin is the red material in the red blood cells, and iron is used in its manufacture. Unless this is present in normal amounts, the body (including the foetus) is unable to gain sufficient supplies of oxygen, and difficulties may be encountered.

Downloaded from Fountain of Knowledge Library

With more severe forms of anaemia (as this condition is called), symptoms will appear. Fatigue (more than would normally be expected), shortness of breath, a pale complexion and swelling of the tissues (referred to as oedema) may occur.

These are very important symptoms, indicating an immediate need for treatment.

However, the doctor usually has taken the matter in hand well before these symptoms are likely to put in appearance.

Treatment is generally very successful. It is usually given in a form that can be taken orally. Many different forms are available. Some patients are sensitive to some iron salts, and changes are necessary. But usually a certain brand is available that is suitable and can be tolerated satisfactorily.

Sometimes another chemical called folic acid is in short supply, and this may be given in conjunction. It is also needed to keep the blood in good order.

By sticking to a sensible iron-rich eating routine, the risks of anaemia are far less. (This is discussed in this section, and you are referred to it for further reading.)

An iron-rich diet is usually a vitamin-rich diet as well. If the mother-to-be acquires this naturally, the need for medication is often reduced.

The original blood test carried out at the first consultation is often repeated at the thirty-second and thirty-sixth weeks of pregnancy, for these are critical times when iron utilisation is high. Any deficiencies must be brought back to normal as promptly as possible.

HEART DISEASE

A certain number of women who become pregnant suffer from heart disease. The figure is small, being around 1 per cent or less. Most have suffered from rheumatic disease in earlier life, and this is the cause of their cardiac problems.

Heart disease is a progressive disorder, and each pregnancy will throw an extra burden on this system.

Provided the patient is sensible, carries out her doctor's instructions, and attends for adequate prenatal visits at intervals which will be more frequent than her healthy counterpart, a satisfactory outcome is usual.

Greater efforts to avoid abnormal weight increases, commonsense care in regard to eating habits, adequate periods of rest, and not performing activities in excess of her ability, all help to keep her fit throughout the term of pregnancy.

The key symptoms that all is not well are breathlessness with activity, and cough. These must be reported to the doctor, particularly if they tend to worsen at any time.

The doctor will want to see the patient every second week from the moment she conceives until the twenty-eighth week. After this, visits will be weekly, or even more often if the doctor has any question. Be guided entirely by his advice. It is most important.

DIABETES

Many diabetics are not diagnosed until adult life, often in the early forties. These are called maturity-onset diabetics; however, some people are born with the condition, or develop it in early life or adolescence. Another group, usually older people, are called "pre-diabetics." They may develop into maturity-onset diabetics. But under certain circumstances, they swing over into the diabetic pattern.

A diabetic is a person with a disorder of the pancreas. This reduces his normal supply of insulin, so he is unable to adequately store circulating sugar. The doctor will check your urine regularly for sugar, for some pre-diabetics will suddenly reveal this in their urine.

Treatment of the pregnant diabetic is usually quite straightforward for the first twenty-eight weeks. But after this, she becomes progressively more difficult to care for. In practice, the best place for these patients is in centres equipped with facilities for caring both for diabetics as well as pregnancies. Many major units in larger cities are equipped along these lines.

The patient is admitted to hospital at about the thirty-second week. This is often essential to enable the sugar levels to be stabilised, to guarantee adequate rest, and to help check other complications which are more likely (mainly pre-eclampsia).

Many patients can be adequately controlled by diet alone. Others may require anti-diabetic medication, and still others may need insulin by injection on a regular basis. On some occasions if the mother's well-being is in danger, termination of the pregnancy may become essential. But others will be allowed to go on until the thirty-eighth week, when induction of labour takes place. In some cases, delivery by Caesarean section is preferred by the obstetrician.

Downloaded from Fountain of Knowledge Library

Rh BABIES

In Western lands such as Australia, New Zealand, and America and the U.K., about 85 per cent of people contain a blood factor, or "antigen" called the Rh factor. This is short for "rhesus," because it was first discovered in rhesus monkeys. These people are referred to as Rh positive. The remaining 15 per cent do not have the Rh factor, and are called Rh negative.

The Rh factor is a complex, inherited characteristic. Problems are possible when an Rh negative woman becomes pregnant to her Rh positive husband and the foetus is Rh positive.

At the time of labour, some of the baby's Rh positive blood enters the maternal circulation. This can cause the production of chemicals called "antibodies," which will circulate in the mother's blood from that time on. The risks of this having an adverse effect on the first baby are not high, but if a subsequent pregnancy yields another Rh positive baby, then risks start to mount. The mother's antibodies can pass the placental barriers and enter the foetal circulation. Here they can have a highly destructive effect. They can progressively destroy the baby's red cells. In severe instances they can result in the death of the infant before birth.

An enormous amount of work has been carried out to try to prevent this situation from occurring. It is now well established that if an Rh negative woman receives a blood transfusion during her life, this may act in a similar manner, and anti-Rh antibodies may be formed. This may have a similar adverse effect on her next baby, whether it be the first or not. In general terms, the risks to the first baby are small, if the mother has not previously been sensitised with a Rh positive blood transfusion or injection. But with each subsequent pregnancy, the risk to the foetus increases dramatically. Many methods of gauging the risk to the infant have been worked out. As pregnancy advances, samples of the fluid in which the baby swims (called the amniotic fluid) can be checked, and the rate of red cell destruction can be calculated from the amount of a product called bilirubin contained in the fluid. The greater the amount, the higher the risk to the foetus.

Babies adversely affected were often given an "exchange transfusion" soon after birth. In this way, their affected blood was completely removed and fresh blood introduced into their system. This method saved many lives.

A New Zealand obstetrician named Liley devised an ingenious system for giving affected

Downloaded from Fountain of Knowledge Library

babies a transfusion while they were still in the womb. Many lives were also saved in this manner.

Dramatic Advance

However, the most recent advance in the field has been a dramatic one. Mothers who are Rh negative and are carrying an Rh positive baby can now be given a special injection of high potency "anti-D gamma globulin" within seventy-two hours of the birth of the baby. This effectively reduces the formation of maternal antibodies to the baby's cells. In short, it removes the possibility of Rh disease occurring in a subsequent pregnancy.

This must be carried out on each occasion. The method has now been in operation for several years, and the results are extremely promising. It may not completely eliminate Rh disease, but could go a long way in this direction.

There are still many women around who are reproducing, and who had their initial pregnancy prior to the introduction of the special serum. They run the original risks, and the serum will be of no value to them, for they have already developed the antibodies.

But for women having their first babies, the method offers unequalled protection. It is one of the major advances of this modern era. In due course it may completely remove the need for exchange transfusions, or for Liley's uterine transfusions. It will make the world a happier place. It will make many mothers much happier too.

VAGINAL DISCHARGES

During pregnancy there is a natural increase in the normal vaginal secretions. This is not serious, and should cause no worry.

However, there are two organisms which have a predilection for reproducing in the vagina of the pregnant woman.

(a) *Candida albicans*. This is a fungus, and is a common occurrence in the vaginal region during pregnancy. It is also more common in the diabetic patient (pregnant or otherwise).

It produces a whitish discharge, which may be copious. This in turn causes tenderness, and often a marked itch at the vaginal entry.

The doctor can readily check this, and on inspection can be fairly certain of the diagnosis. But simple tests are available which reveal the fungus under the microscope.

Treatment is usually quite successful. Suppositories of nystatin canesten or other "anti-fungal" antibiotic are inserted once or twice a day for a week, thence daily for a further fortnight, or even longer. Reinfection from the sexual partner may occur, producing further problems unless therapy is continued.

(b) *Trichomonas vaginalis*. This is an infection with a micro-organism which has a wildly wagging tail and can propel itself along. It produces a very irritating yellowish discharge. The organism can be detected with straightforward pathology tests. When detected, natamycin suppositories are ordered and these are usually highly effective. Frequently, local applications are needed to reduce the external irritation brought about by the discharges. This condition is usually contracted from an infected partner at intercourse.

MULTIPLE PREGNANCIES

Normally, the average pregnancy consists of one single foetus. But about once in ninety cases, twins occur.

The rate at which triplets occur is 1 in 90 x 90 pregnancies, and quadruplets 1 in 90 x 90 x 90. This is the rate in Western lands. It is more common in Africa and Asia where a larger hereditary factor apparently plays a part.

There are two types of twins: "Binovular" twins occur when two separate eggs (or ova) are released and fertilised at the same time. Each foetus is a separate entity and is quite distinct from its fellow. "Uni-ovular" twins come from one single egg which has prematurely divided into two separate entities.

Twins are often diagnosed before their birth, but about 20 per cent are not recognised until the moment of delivery. Features which make a patient and the doctor suspect multiple births are mainly the size of the abdomen and womb which are larger than would be expected at any given time.

Sometimes two heads may be felt through the abdominal wall by the doctor's examining hands. Frequently, the only sure way is by X-ray or ultra-sound examination of the womb. Two separate heads and bodies can be clearly detected in this manner.

Generally, multiple births proceed to term normally. But there is an increased risk of certain complications taking place, so the mother may be requested to attend more frequently for her prenatal examinations. Some cases end in premature labour.

Awareness Important

Other complications can take place. But they are mostly in the province of the obstetrician. His

Downloaded from Fountain of Knowledge Library

job is to check for them on a regular basis. Whatever treatment is needed, it is his duty to prescribe and carry out.

Certain other problems may arise at the time of the confinement. These, too, will be dealt with in a practical manner if and when they arise.

The foregoing problems have been mentioned to give an idea of some of the possibilities. Although the majority are unlikely to come your way, there is always a small chance. It is best to know this. By being aware of some of the more important symptoms, a person is more attuned to the need for prompt medical attention.

This will also accentuate the need for careful choice of the doctor who will undertake your care throughout the pregnancy and confinement. It will also govern your choice, and impress on you the need for close proximity of a well-equipped modern hospital to take care of you throughout the time you are pregnant (if the need arises), and most certainly at the time of delivery.

The details are meant to inform, not to frighten or produce apprehension or dismay. The great majority of confinements turn out satisfactorily, both for mother and baby. Never forget this, but never overlook any danger signs. These must be reported promptly at all times. It is in your own interests.

Downloaded from Fountain of Knowledge Library

Chapter Ten:

Termination of Pregnancy

Many pregnancies are ended abruptly and spontaneously by nature for reasons unknown. It is now believed this is nature's way of maintaining a healthy human race. But "legal terminations" are also being carried out in increasing numbers when the health of the mother is jeopardised.

TERMINATION OF PREGNANCY

An enormous number of pregnancies never reach full term. For a large variety of reasons, they end prematurely. When this takes place before the twenty-eighth week of pregnancy, it is termed an abortion.

Many people prefer to use the more euphemistic term "miscarriage," for abortion in some minds conjures up criminal acts or acts of an illegal nature. These of course play only a small part in the total picture, and they appear to be decreasing with variations in laws around the world.

When pregnancy reaches the age of twenty-eight weeks, it is legally considered to be "viable" or alive, even though a baby born at this age would be hard pressed to survive normally.

The figures for naturally occurring abortions or miscarriages vary considerably. Some experts claim that about 10 per cent of all normal pregnancies end in this manner. Others claim the figure is more like one in four, or 25 per cent. However, more recent work in the United Kingdom now claims that as many as 70 or even 80 per cent of all pregnancies terminate prematurely by natural events.

These latter claims are based on careful studies of many thousands of cases. Many now believe that an abortion is merely nature's way of maintaining a healthy line in the human race. Now genetic studies and chromosomal patterns can be studied in more detail than ever before with newer techniques, it seems that the overwhelming majority of abortions are really the result of genetic deformities. Therefore, nature has shed them early in pregnancy to avert the multitude of hazards to which a genetically affected human is subjected throughout life.

Nature at Work

By methods not clearly understood, a genetically deformed embryo has greater difficulty in being accepted by the lining of the womb. Certain natural influences, it appears, act against it. The result is a rapid shedding very early in pregnancy. Indeed, most women are completely unaware that pregnancy had taken place, and less aware that a miscarriage in fact has occurred.

Often this is reflected in a "late menstrual

Downloaded from Fountain of Knowledge Library

period." When it does arrive, it may be heavier than normal, or there may be a few clots. It may be completely pain-free, or there may be a little more discomfort than usual. But this is invariably accepted as part of the lot of the female, and little fuss or bother is made of the unrecognised event.

Other instances, of course, last longer. Nearly three-quarters of recognised abortions take place between the sixth and tenth week of pregnancy. Definite reasons are hard to come by. Some claim that there is a temporary reduction in production of the hormone called progesterone at this time. This could be responsible for the embryo becoming dislodged from its position in the uterine wall and being swept away.

It seems that some abortions may be generated by infections and fevers in the mother at the time implantation is occurring. Perhaps viruses in her system pass over the placental barriers and gain access to the embryo, producing damage that results in its prompt release.

Some experts believe that psychosomatic causes play a part. The nervous system and brain are highly complex structures. It seems that through the complicated neural networks they may cause the generation of hormones that also predispose to premature release of the embryo from the uterine wall.

Sometimes the male partner may be responsible. Fifty per cent of the chromosomes and genes of the fertilised ovum are from his spermatazoa. Therefore, when union occurs, if defects are present consistently in his contributing half, then this could regularly predispose to miscarriage. Cases are on record where a woman sustaining multiple (or habitual) abortions remarried, and the pregnancies occurring with the new partner proceeded uninterrupted to full term and the birth of a normal, healthy baby.

NORMALLY OCCURRING ABORTIONS

Technically, several different kinds of abortions are recognised by the doctor. But from a practical point of view, it doesn't matter too much about the technical features. What matters most is that a sudden halt occurs in the normal progression of the pregnancy. Often this requires prompt medical attention to avert serious consequences.

The first indication that all is not well is that vaginal bleeding commences. This may be any time during the first twenty-eight weeks of pregnancy, but more commonly in the six- to ten-week period.

The bleeding might commence as brown spotting which may gradually or rapidly increase in volume and nature. It may become red, and be associated with cramp-like pains in the lower abdominal regions. The amount may be small or it may be profuse.

If it starts off red then gradually reduces and becomes brown, the chances are fairly high that it will settle down. If the brown discharge continues, the risk of abortion increases. If brownish discharge increases and becomes bright red, then there is a far greater risk of the embryo aborting.

Many cases settle down, and proceed thereafter to term. But many gradually continue, and finally abort completely. The patient may suddenly feel as though she "is passing something" (a common expression). This may be accompanied by several severe cramp-like pains, more bright-red bleeding, then a reduction in both. Sometimes the products of conception are self-delivered at the lower end of the vagina. At other times, they become stuck part way, and the bleeding and discomfort continue.

Whatever happens, bleeding with or without pain is certainly an urgent recommendation for prompt medical assistance. A proper examination will enable the doctor to advise whether simple measures are likely to allow the impending abortion to settle down, or whether surgical intervention is necessary to avoid further risk and blood loss to the patient.

In the latter instance, of course, prompt hospital admission is arranged, and the correct procedures undertaken forthwith, before further haemorrhaging takes place. Many women are upset when an abortion prematurely ends a pregnancy they had wanted. However, most doctors take the sensible view and endeavour to explain the position to their patients. This is usually nature's way out of a situation that could produce later problems to the parents.

When this is pointed out, a different complexion is usually given to the whole picture, and most patients are then quite satisfied and indeed glad that it ended in this way, rather than face possible difficulties in the future.

THERAPEUTIC ABORTION

In recent years great changes have taken place in the attitude towards therapeutic abortion. This means that abortion is carried out by a doctor as a method of treating his patient, and for her welfare.

Prior to this, abortion was considered a criminal offence, both for the person carrying

Downloaded from Fountain of Knowledge Library

out the operation as well as for the participant-patient. Only under very unusual circumstances was the action legally condoned.

However, world-wide attitudes are changing. As the population explosion becomes an increasing problem in many countries, the laws have been reshaped or indeed changed completely. Now, in many Scandinavian countries, Eastern lands and Japan, abortion is freely available and indeed actively encouraged for social and economic reasons.

In quite a few places it is readily available completely free of charge, and carried out in government hospitals under their care and at their expense. Certain safeguards are present, but many consider it an attempt by such countries to survive the pressing urgency of population problems.

The Western world has been a little slower and more cautious. However, Britain has led the way, and in April 1968, the "Abortion Act of 1967" came into force. Basically, this removed many of the previous barriers to the legal termination of pregnancy for therapeutic reasons. Abortion became legally permissible, provided a set of clear-cut regulations were followed. However, the actual interpretation of some of these requirements seemed open to wide variation. The result has been an enormous increase in the rate of legal terminations being carried out.

From the low point in 1968 the figures rapidly climbed to a peak of well over 160,000 in 1974. After this they started to decline slightly, probably because abortion reform became available in certain other European countries, and women who travelled to the U.K. for treatment now found this was no longer necessary.

However, these figures pale into insignificance when compared with figures for Japan where, as far back as 1955, an estimated 1.7 million terminations were carried out. This has now settled down to a fairly constant figure of around 750,000 a year—still a vast number, nevertheless.

In America various states have undertaken "reform," and termination of pregnancy is now more readily available.

The Australian scene has taken a major change in recent years. South Australia introduced variation to its state laws early in the 1970s, making it more readily available under a closely scrutinised set of rules. New South Wales left the law intact, but judicial decisions later opened the way with the existing legislation for a much wider interpretation to be given.

The End Result

The net result of all this has been a rapidly increasing rate of legal terminations. Indeed, some doctors believe the interpretations have made it all too easy. But the proponents claim that these enlightened measures have almost entirely removed criminal abortions, and these were the areas that produced so many medical problems in years past.

So, whether it is for better or for worse, there seems little doubt that the new attitude to legal terminations will be here, and in most Western countries, for a long time to come.

Although some will use it in its widest interpretation and allow cases of a questionable nature to receive treatment in this manner, many other doctors will tend to stick to what they believe is right. They will recommend legal termination when it truly means that the total health and welfare of the lives at stake are seriously involved.

At least, as the proponents claim, it has largely reduced (and in many countries completely eliminated) the amateur, and the backyard, illegal operator from the scene. Enormous numbers of women (claimed to be 10 to 15 per cent of all pregnancies in Western lands) ended up having illegal (criminal or "induced") abortions carried out.

The circumstances were often anything but ideal. Hygiene and sterility were often lacking, and in some cases non-existent.

Actions were often rushed, and the operator was often quite unsuited and inadequately trained for the operation. Many cases of bungling inefficiency are on record. Many patients became infected and deaths occurred on numerous occasions. Some women had to be subsequently admitted to hospital for a "clean up" operation, and treatment of their sepsis (infection).

At least, under the new system, terminations are carried out in properly equipped hospital operating theatres, complete with all facilities to meet any eventuality. The surgeons are trained gynaecologists, quite expert with their duties.

There are certain medical indications for the need for therapeutic abortion (or legal termination). Carried out in its rightful place, this can be of major assistance to a mother in need. However, before any mother rushes into an abortion clinic to have the baby destroyed (and

Downloaded from Fountain of Knowledge Library

that is what it actually is) please think of the moral issues involved. The foetus you destroy is actually a living being. Though small, it is a perfectly formed human being. Is it right that you should take the life of this human being simply because it is inconvenient for you to give birth to it? Have you the right to say whether it shall live or die merely because its presence might curtail your social life, strain your budget, interfere with your career or embarrass you by its presence? You have no moral right to decide whether this unborn child shall live or die. If you make the wrong choice, you will never be free of the guilt pangs which people with consciences know when they choose abortion as an "easy way out."

Indications. Here are some of the more likely reasons as to why a legal termination may be considered by the gynaecologist:

- *Severe heart disease.* If pregnancy is complicated by severe forms of heart disease, and cardiac surgery to the mother is impractical, then termination may be the only way out for her, to save her own life.
- *Chest disease.* T.B. is rare today, but occasionally this may be a reason, particularly if the patient is unable to tolerate her medication.
- *Kidney disease.* If the kidneys are severely diseased, it may be imperative to terminate the pregnancy.
- *Psychiatric conditions.* Certain cases benefit from a termination. (Indeed, this is the aspect most openly abused. However, the doctor should genuinely assess each case that presents, and make a decision after carefully examining the full case-history.)
- *Cancer.* Malignant disease in young women is often rapidly growing, and may prove fatal in the event of pregnancy. Such a patient would be a certain candidate for termination.
- *Disorders of pregnancy.* Sometimes severe symptoms occurring in pregnancy warrant termination.
- *Viral infections.* Rubella contracted in the first twelve weeks of pregnancy is almost certain to yield severe congenital malformations. Termination is usually offered to these women. Some other viral infections are also possible reasons for interference.
- *Rh disease.* Certain severe cases of Rh disease warrant termination.
- *"Eugenic reasons."* Some high-risk pregnancies warrant termination, particularly when it is suspected with a high degree of accuracy (and this is often possible today with newer concepts of prenatal diagnosis) that the infant will be mentally defective or malformed. (Conditions in this category include Down's syndrome—mongols, and infants with *spina bifida*, a serious malformation of the spinal system.)
- *Sexual assault:* Rape, incest, and similar forms of sexual assault are also considered to be suitable reasons for legal termination.

THE FUTURE

Many experts believe that with the increasing use of contraceptive methods, and their ready availability in many and varied forms, the need for terminations will gradually reduce with the progression of time.

Downloaded from Fountain of Knowledge Library

Chapter Eleven:

The Exciting Happenings of Pregnancy

Enormous internal changes take place during pregnancy. A knowledge of what is happening inside your body makes it all so much more interesting.

Pregnancy is the most intimate and heart-warming experience in the life of a married couple. Not only are the events which lead up to it very personal, but the actual incident represents a merging of the essential features of both partners.

Characteristics of both parents, including physical, mental and psychological elements, are united in an amazing manner. These factors take place at the moment of conception, and are inevitably destined to go with the new life from that point onwards to the end of his life.

In recent years, more is becoming known of this life before birth. Chromosomes, the microscopic filaments that bear the genes, the actual heredity-bearing organs, can now be studied in detail by the use of special mechanisms. The amazing extent of "genetic predetermination" is becoming understood more and more as these intricate items are visualised under powerful microscopes.

By taking cells from the amniotic fluid, the watery substance in which the baby floats in prenatal life, and examining these, a great body of information can be adduced.

The sex of the developing baby can be determined. If the infant is likely to have certain physical abnormalities, this too can often be discovered. Indeed, in several trials carried out in the United Kingdom, the researchers even claimed they could give an indication if the developing baby would grow up to be a criminal!

The Two Elements

In every pregnancy, there must be two elements, a male and a female. The male contributes to reproduction the single-celled units called spermatazoa. These are produced as a continual, ongoing process in the testes which are located in the scrotum.

As they are produced, they are conveyed by a narrow canal called the *vas deferens* into the body. Here they are deposited in a storage chamber located behind the urinary bladder, and named the seminal vesicles.

Certain glands add fluid to this storage tank, so that the sperms are able to move actively about. The fluid contains nutritive elements to enable them to keep alive and very active.

Each sperm has a head and an actively waving tail which is used to propel it along. Located in the head is the nucleus, and deeply inside this, are positioned the tiny filaments called the chromosomes. These contain small knobs along

Downloaded from Fountain of Knowledge Library

their length, termed genes. The chromosomes and genes are the heredity-bearing elements of the cell.

Just before they are discharged by the testes, the number of chromosomes in each sperm is halved. A normal cell contains forty-six, but the sperm contains only twenty-three. Included in this number is the sex-determining chromosome. This is referred to as either an X or Y chromosome.

When the sperm finally unites with the female counterpart, the ovum (which also has divided so that it contains twenty-three chromosomes), the sex of the subsequent infant will be immediately determined. An X-bearing sperm will produce a female; a Y-bearing sperm will produce a male. The ovum contains only X chromosomes, so the male contribution is the sex determinant.

Recent Research

In recent years much research has gone into trying to discover which sperms carry the X element and which carry the Y chromosome. If this could be perfected, then the sex of the offspring could be determined by choice.

Recent work in the United Kingdom now claims to have gone a long way in this regard. Using complex procedures, it seems that a solution composed chiefly of X-bearing cells, and another of Y-bearing sperms can be prepared. Details are still being worked out, but probably by the process of "A.I." (artificial insemination) it may be possible, very soon, to choose the sex of your baby. It is pointed out that this is still at the laboratory level, but the future prospects are intriguing.

However, at present, for practical purposes, it still remains a matter of chance. When fertilisation takes place,

X (sperm) + X (ovum) will produce XX which equals a female.

Y (sperm) + X (ovum) will produce XY which equals a male.

Another idea put forward by some American obstetricians not long ago suggests that certain sperms are more prone to destruction by vaginal acids the nearer the date of ovulation. Therefore, they claim, it may be possible, using their carefully calculated formulations, to elect the sex of your baby by timing intercourse in relation to the date on which the female egg is released. As no massive swing has occurred since their ideas were promulgated, it is assumed that right now people prefer to rely on chance, or that the system is too fanciful to be practical.

Most, it seems, prefer to let nature have its own way!

Sperms

Great numbers of sperms are present in seminal fluid. The volume gradually accumulates until intercourse occurs. Then, with the overpowering and very sensuous experience called orgasm (known colloquially as a "climax"), between two and four ml of fluid are deposited high up into the female's vaginal tract. The act is known as intercourse, and the emission of the fluid is referred to as ejaculation.

This represents the culmination of copulation (intercourse), and for the male is the most climactic part. It is associated with enormous psychological overtones for both sexes. Indeed, it is the tremendous physical and mental impact of this event that has given "sex" (in its fullest meaning) such forceful connotations in the world at large.

Because the erect male penis is firm and elongated during intercourse, the seminal fluid is deposited usually at the far upper end of the vagina. In the fluid there are myriads of actively swimming sperms, with their tails thrashing madly about. The number may be as high as 700 million, although on average, it is around the 200-million mark.

Imagine this: There are enough sperms present in one single ejaculation to totally populate the entire United States of America in one fell swoop! Or it would populate a less populous nation such as Australia fifteen to twenty times over! But the truth is that only one single sperm is required to produce the anticipated pregnancy!

This represents nature's absolute attention to detail. From the strictly biological point of view, nature's task is to guarantee reproduction of the species. Therefore, to be absolutely certain this takes place, a superabundance is generally provided.

The many attractions of intercourse, the male-female relationship, and the pleasurable sensations to be derived from physical contact are another capricious ploy of nature. But sensible couples realise that the implications of sexual intercourse, although pleasurable and a physical and mental delight, are best reserved for the marital unit. The flow-on—namely, the production of a new life—requires much more than the promiscuous casual relationships that premarital or extramarital sex can offer. New life means the need for a home that can succour and care for it, in all aspects.

Downloaded from Fountain of Knowledge Library

Once orgasm and ejaculation are complete, the physical aspects of the male partner's role are over—at least for the time being.

The Journey Begins

The sperms, with tails wildly thrashing, quickly find their way through the cervical canal into the womb, which is technically known as the uterus. The cervix is the neck of the womb, jutting into the upper part or vault of the vagina. A narrow canal allows penetration into the inner part of the womb, which is lined with special cells called the endometrium.

If intercourse occurs about midway through a menstrual cycle, then the chances of encountering an egg (or ovum) are quite high.

Several thousand sperms will manage to penetrate into the inner part of the womb but untold thousands perish in their fight to gain entry.

Branching out from either side of the uppermost part of the womb are two canals which lead into the Fallopian tubes (or oviducts). The tubes are several inches in length, and they end at a point closely related to the ovary on each side.

Once a month, the ovary produces an egg or ovum. There are two ovaries, one on each side, which again indicates the attention paid by nature. If one should become destroyed for any reason, there is always the back-up second one on the opposite side.

When a female baby is born, its ovary contains thousands of primitive eggs. When puberty occurs at the age of nine years or onwards, the ovaries suddenly commence activity, and produce an egg on a regular twenty-eight-day cycle. In a twenty-eight-day-cycle woman, this occurs on about the fourteenth day. The egg comes to the surface of the ovary, and bursts through the surface, to become free in the pelvic cavity.

When Conception Occurs

The Fallopian tube, which is very close by, has finger-like tentacles which help sweep the released egg into the tube. If at this point, the egg encounters a sperm that has managed to survive and make its way into the outer limit of the tube, a sudden fusing takes place, and a "fertilised ovum" develops.

This is the moment of conception, and at this point the heredity traits of the new life are sealed permanently. At this moment also, the sex of the new life is positively determined.

From this point on there can be no change. It is an amazing thing that mental and physical characteristics which may not become evident for many years, perhaps decades, are intimately sealed into the newly developing life in this split second of time. At this time also, the possible production of twins, or triplets or other forms of multiple birth is determined.

Multiple pregnancy can occur from the simultaneous release and fertilisation of two or more ova (the so-called "dizygotic multiple pregnancy"), or from the early division of a fertilised single ovum (called "monozygotic twins").

The incidence of twins is one in ninety pregnancies, of triplets, one in 90 x 90, and of quadruplets, one in 90 x 90 x 90 pregnancies in Western countries. Twins are more common in Africa and Asia. Dizygotic twins are more common in families in which there is a history of twins, in women who are older, and the chance increases with larger families.

In recent years, certain hormonal products used to treat women who are having difficulty in reproducing (called infertility), seem to make some more prone to multiple births than women conceiving normally and without difficulty.

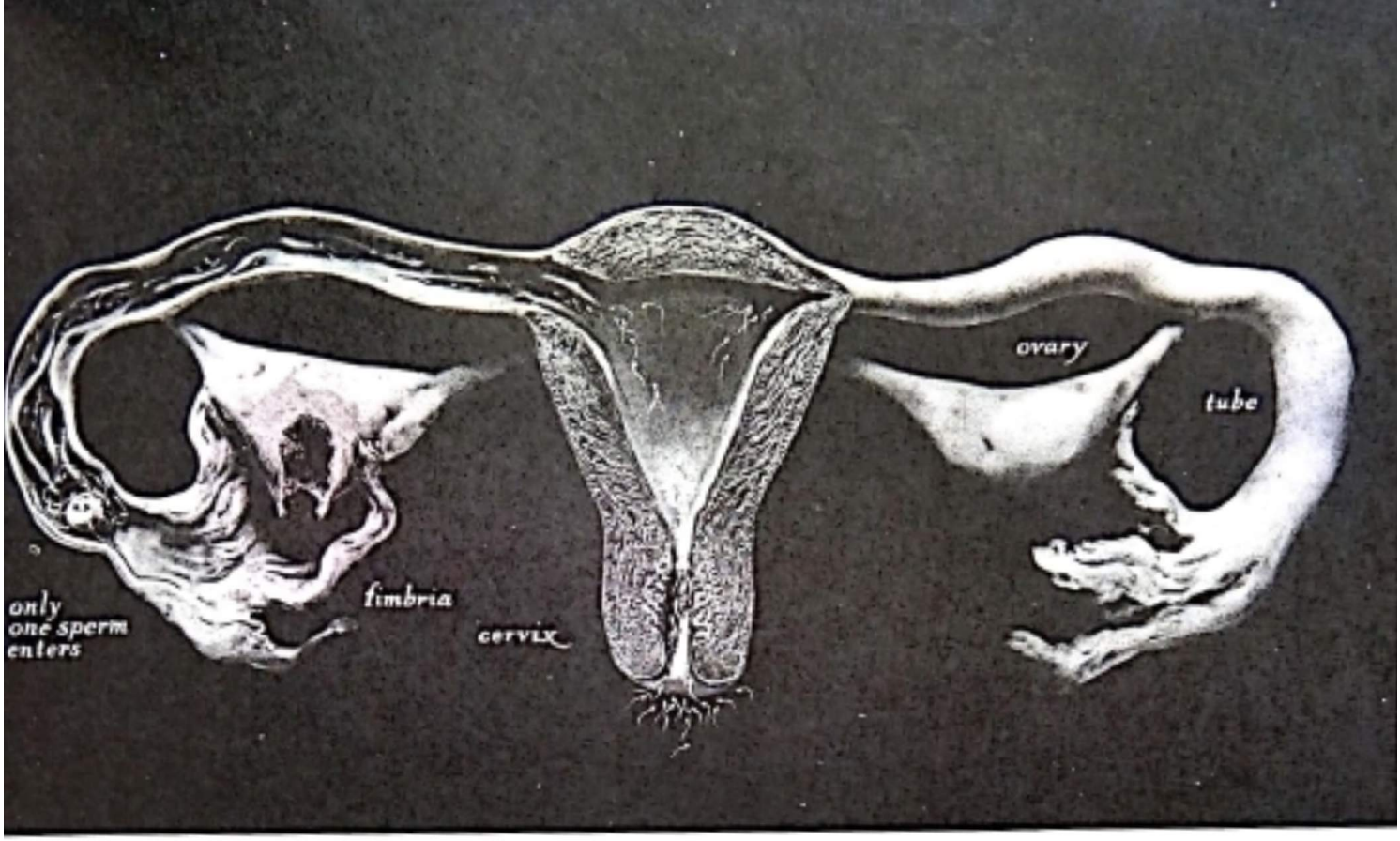
The Corpus Luteum

Back to the ovary. Here there is a sudden gap left when the ovum escapes. There are about 100-200,000 other primitive eggs still left behind, and one by one a certain number of these will be released. But for the moment, egg production ceases. The hole left by the escapee is filled with blood. In a short time special cells grow into the space, to produce an organ called the corpus luteum. This rapidly starts to manufacture chemicals or hormones, which have a dramatic effect on the inner part of the tube and the endometrium, the lining of the womb.

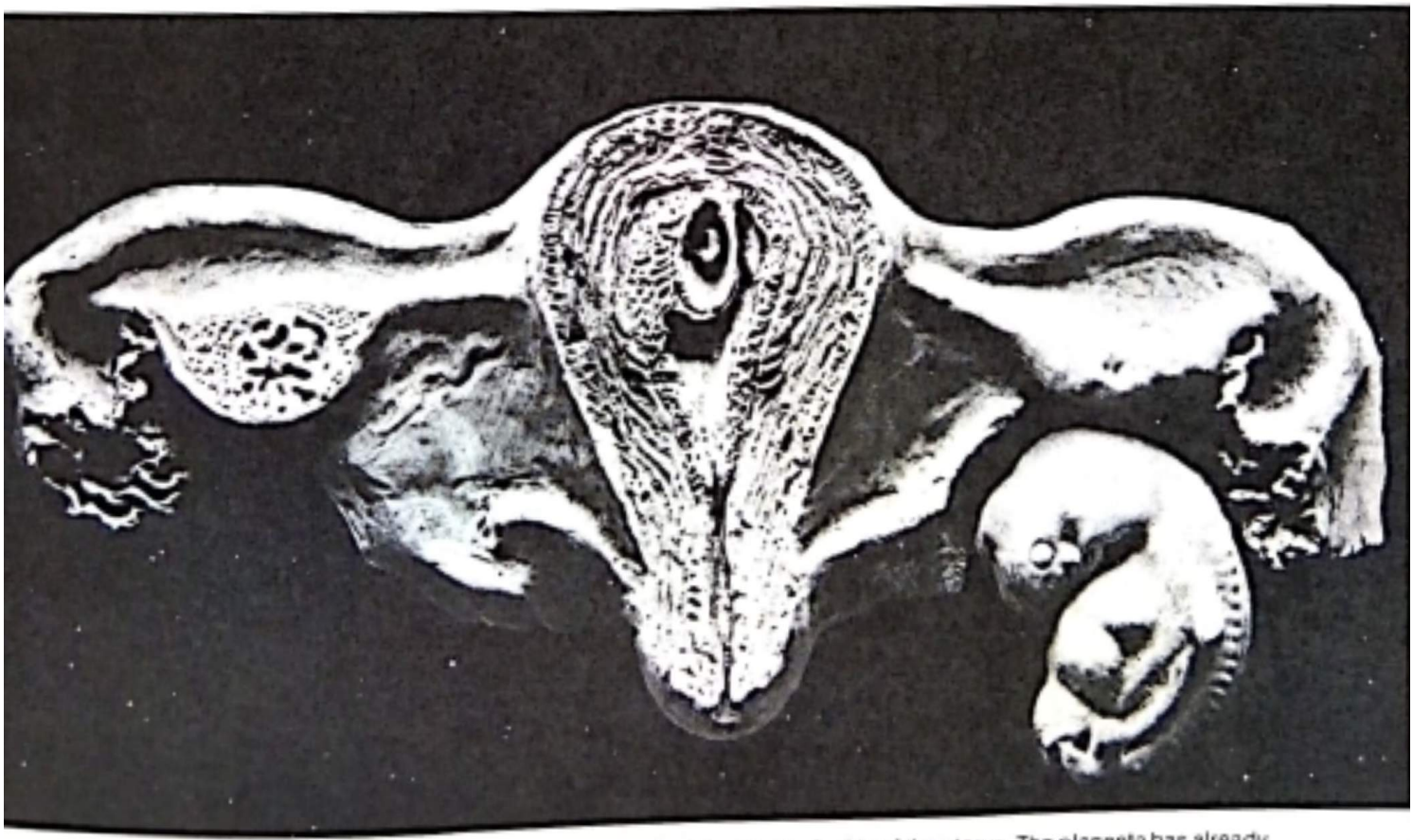
Each month the lining is prepared to receive a fertilised ovum. If this takes place, then other changes quickly occur. But if pregnancy does not ensue, this is gradually shed in the form of a normal, regular menstrual bleed or "period."

In the lifetime of any one woman, the number of times pregnancy will take place is extremely small. But fortunately the ovary and womb are not aware of this, for they would otherwise soon despair! But they tenaciously carry out their appointed duties with unfailing regularity, month in and month out. However, if the ovum is fertilised, then there must be great rejoicing. But the chances are not high. Unless fertilised within

Downloaded from Fountain of Knowledge Library

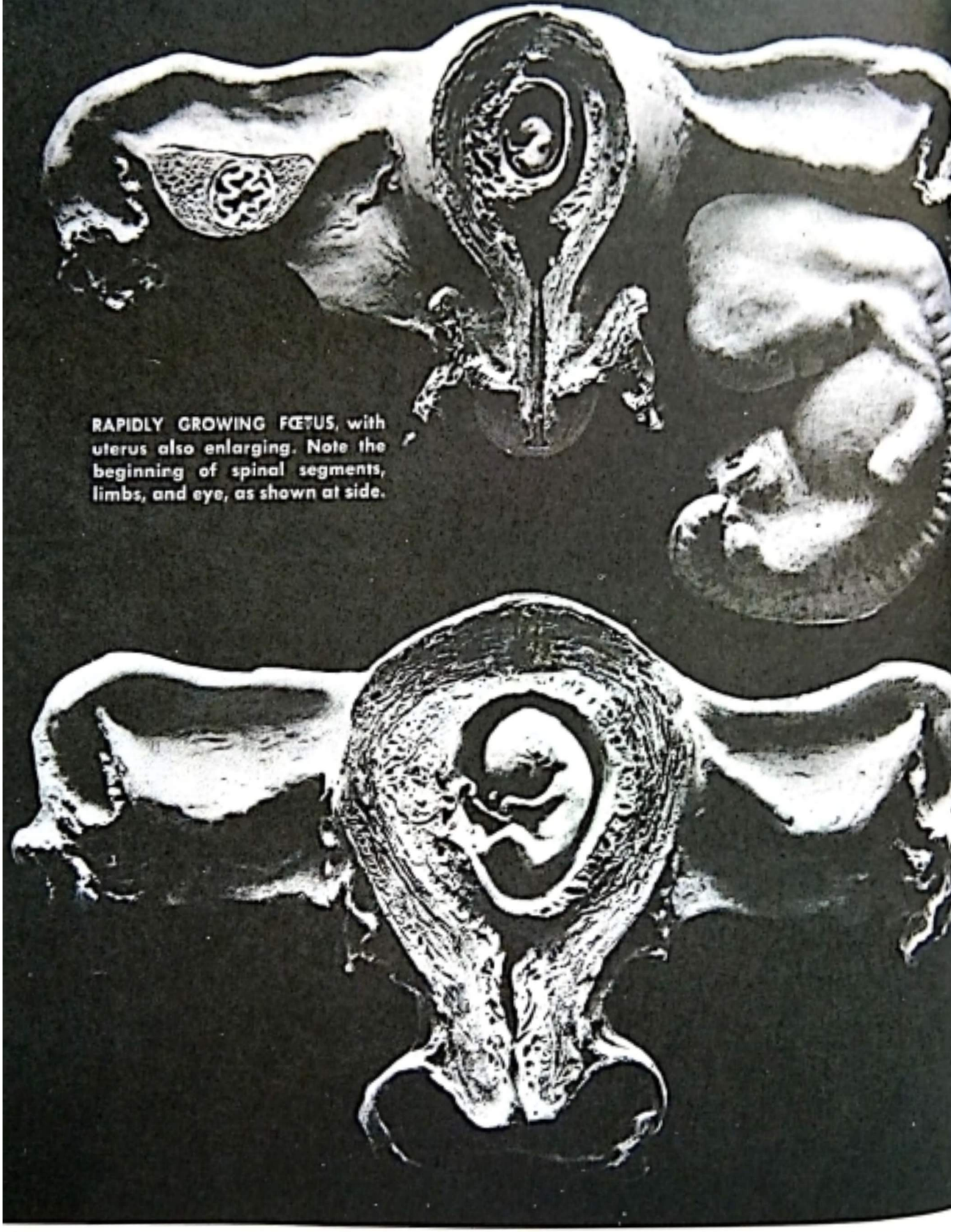


NORMAL FEMALE GENITAL ORGANS. Picture shows sperm cells (greatly magnified) entering cervix and swimming through uterus and tubes toward ovum, the large single cell in the tube at the left. It has been released from the ovary. Note the large cavity in ovary, where the corpus luteum will develop later. Here the hormone called progesterone is produced.



FERTILIZED OVUM has moved down the tube and attached itself to the inside of the uterus. The placenta has already begun to form inside the uterus. The inset at lower right shows the general shape of the embryo at this stage (greatly enlarged).

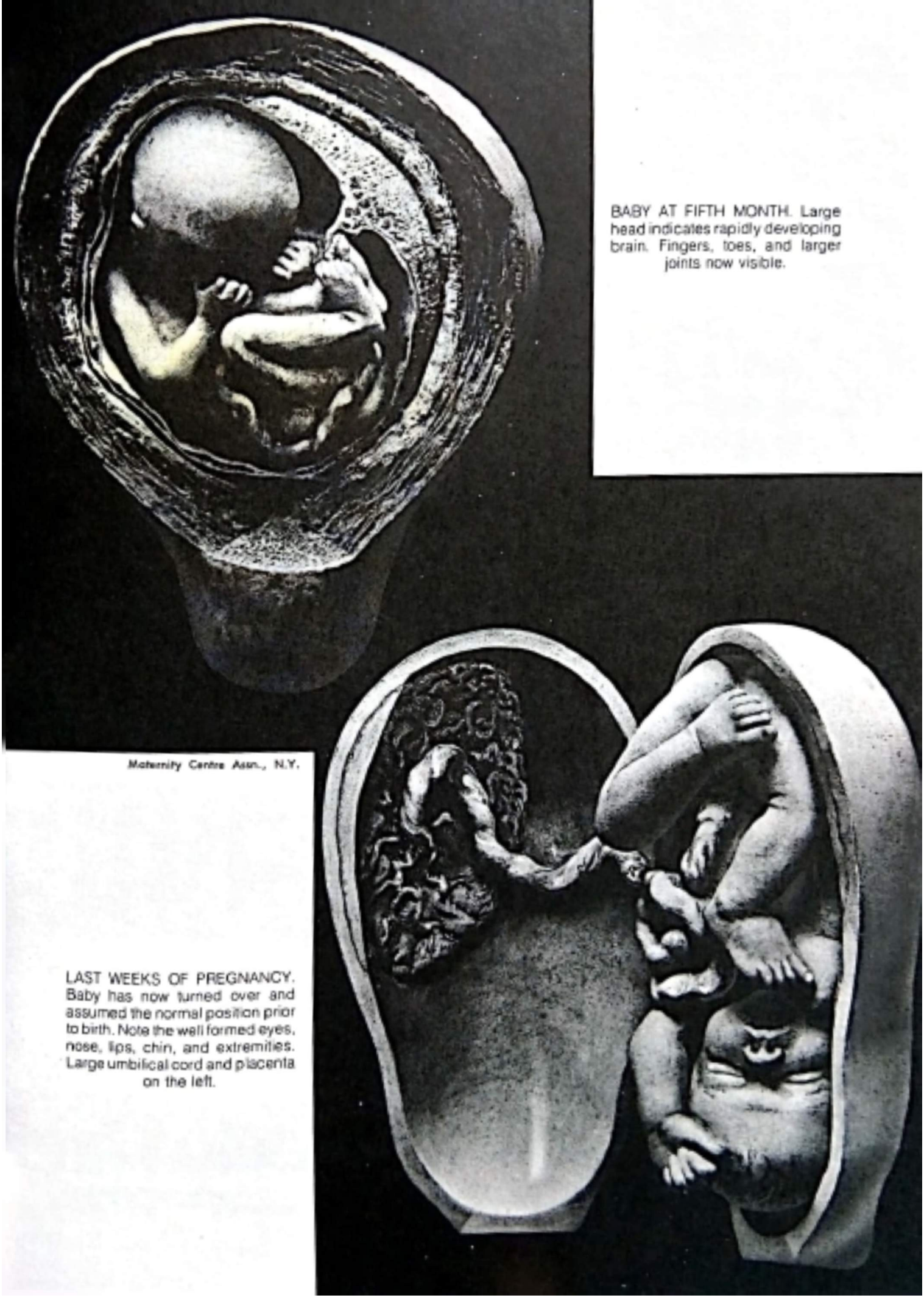
Downloaded from Fountain of Knowledge Library



RAPIDLY GROWING FŒTUS, with uterus also enlarging. Note the beginning of spinal segments, limbs, and eye, as shown at side.

FOETUS, AT FOUR MONTHS. Note umbilical cord attaching to placenta at left. Limbs and ears are forming. Baby is floating upright in amniotic sac.

Downloaded from Fountain of Knowledge Library

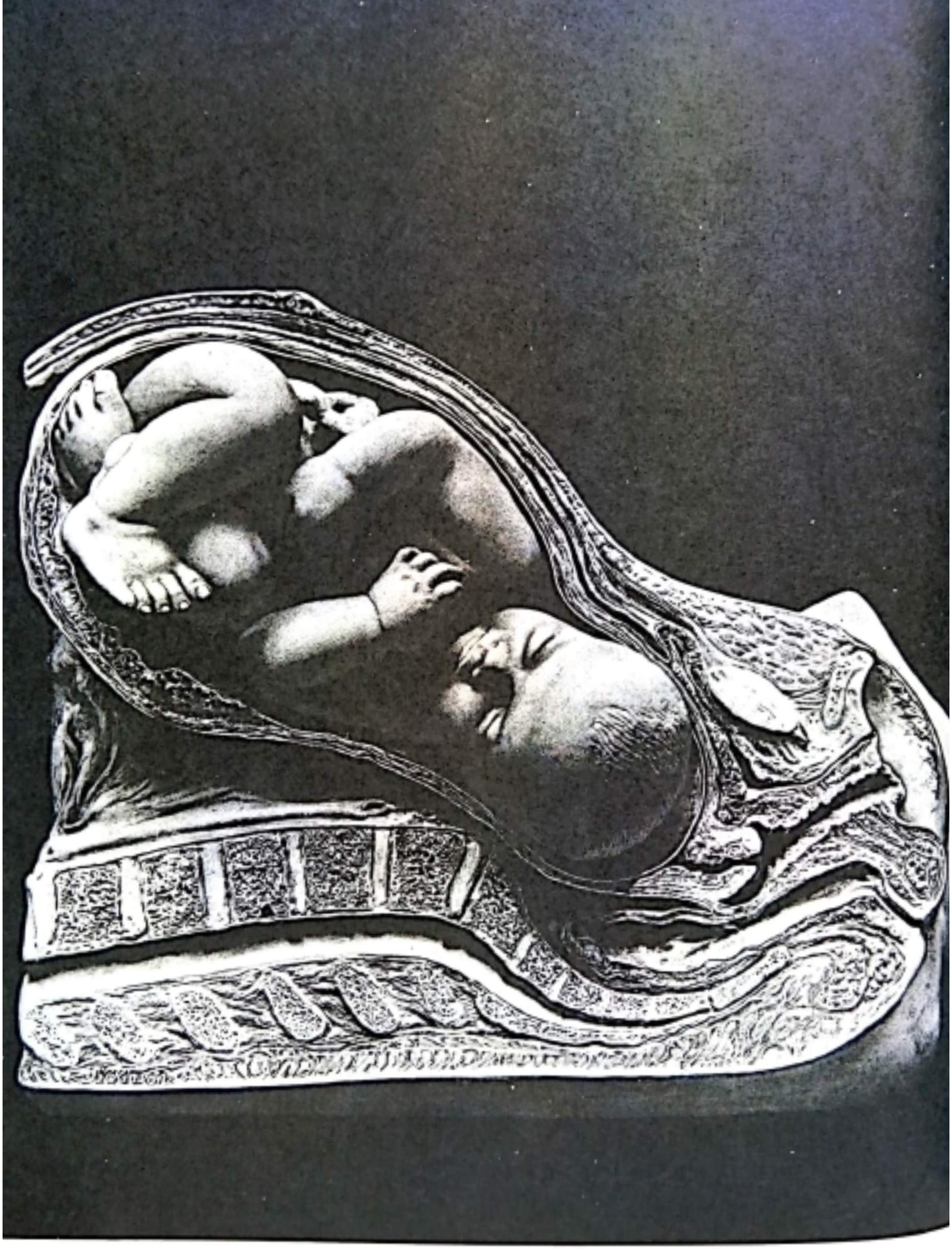


BABY AT FIFTH MONTH. Large head indicates rapidly developing brain. Fingers, toes, and larger joints now visible.

Maternity Centre Assn., N.Y.

LAST WEEKS OF PREGNANCY. Baby has now turned over and assumed the normal position prior to birth. Note the well formed eyes, nose, lips, chin, and extremities. Large umbilical cord and placenta on the left.

Downloaded from Fountain of Knowledge Library



FULL-TERM BABY READY TO BE BORN. Note the perfectly formed fingers, toes, and facial features. Babies normally come head first. The head opens the way for the rest of the body to follow.

Downloaded from Fountain of Knowledge Library

NORMAL POSITION OF BABY passing through birth canal. As the uterus contracts, the head moves downward, opening the way for the rest of the baby to follow. Amniotic fluid provides normal lubrication to aid in the delivery. Baby's skull bones overlap to reduce size of the head during the birth process.

BABY'S HEAD IS DELIVERED. Doctor checks to see if cord is around neck. With gentle traction, the baby now passes out quite easily. Cord is still attached to placenta. After cord is cut and tied, Baby is placed in crib. Doctor carefully checks Baby's nose and mouth to be sure he is breathing normally. Placenta usually comes away within a few minutes.

Downloaded from Fountain of Knowledge Library

about thirty-six hours of its release, the egg disintegrates and dies. A sperm can live for only about forty-eight hours outside the male. Therefore, there is a period of about thirty-six to forty-eight hours in any given menstrual month when pregnancy can possibly occur.

Considering the number of allegedly unwanted babies in this hard, cold world, it is amazing how frequently intercourse must take place at the crucial moment. But nature is really artful, as has already been pointed out.

Not All Chance

Due to hormonal changes, most women have their sexual desires markedly augmented so that the zenith coincides with the moment of ovulation or soon after. So it is not all apparent chance and luck. It is really by very cleverly devised means that it occurs so frequently this way.

As soon as conception occurs, and the chromosomal count is reconstituted back to forty-six (including the XX or XY ones giving the individual his sex characteristic), the cell commences to divide and divide again. All this time it is gradually propelled down the length of the Fallopian tube by gentle muscular movement aided by pulsations from the "cilia," little hairlike projections that protrude from the cells lining the tube. These set up sweeping waves that help carry the egg towards the cavity of the womb.

By the time the egg has reached the womb, the lining is quite ready to accept it. Very quickly the egg becomes embedded in the endometrial layers, usually at the upper part of the womb, either toward the front or back. Very occasionally it becomes embedded low down near the uterine outlet. But this can lead to problems at a later stage, and more has been told of this in relation to a condition called *placenta praevia*, in another chapter. (See Chapter 9 in this section.)

By now the egg has become a solid mass of cells called a *morula*. Under the influence of hormones from the *corpus luteum* of the ovary, small projections called *villi* grow from the outer surface of the egg. These help it become embedded even more intimately. Very rapidly, in fact, in a matter of days—the junction between the uterine wall and the egg deveops into a powerful organ which is to become the placenta, and finally the "after-birth" at the time of baby's birth.

Life-support System

This is the organ through which the developing baby will come into very close contact with the mother's blood supply. In fact, this becomes its supply channel, for food, oxygen, vitamins and all other nutritional supplies. It also becomes the developing infant's method of disposing of its own waste products.

At no time does the mother's blood actually come into contact with that of the baby. The two are completely separate, but they are separated only by a very fine barrier. Through this barrier diffuse both ways, foods and waste products. It is an amazing exchange system, but a very workable and practical one.

The fertilised egg quickly develops. The placenta forms, and the rest of the womb fills with fluid called *liquor amnii*, or amniotic fluid. The baby is known as an embryo in the early stages, and as it further develops it is called a foetus (which is sometimes also spelled fetus).

Besides being the exchange site for food and oxygen, the placenta is also a powerful factory. It produces chemicals called hormones which are vital to the safe development of the baby. An important one is called "H.C.G.," short for human chorionic gonadotrophin. After a few weeks this production becomes high, so much so that excessive amounts circulate in the blood and are excreted by the mother in her urine.

This forms the basis of the pregnancy tests which are often used to prove or disprove the presence of pregnancy in a woman who is unsure. Using a special technique called radio immunoassay, or a simpler "immunological test" on the urine, the hormone's presence can quickly be determined. It means the doctor is taking advantage of a naturally occurring situation when he has this test carried out.

Oestrogen and Progesterone

But the placenta also produces other chemicals in conjunction with the ovaries. Oestrogen and progesterone are produced, together with other hormones which affect all parts of the system. In fact, everything is now geared to the safe development of the baby, and to his needs after his birth. For this reason, the breasts commence development very early in pregnancy under this hormonal influence.

They become larger, the nipples more supple and bigger. The milk glands enlarge and after a while start to produce fluid. This is very thick, yellowish and creamy at first, and is called colostrum. But soon after birth, a regular, highly

Downloaded from Fountain of Knowledge Library

nutritious milk supply quickly becomes established. This fulfils baby's needs, and may continue on for many months.

Development of the Foetus

To give an indication of how the foetus looks during the early weeks of pregnancy, the following table sets out some of the features of development.

Where a miscarriage has occurred in early pregnancy, a casual examination of the foetus will reveal many of these features.

It is pointed out that many conceptions terminate in miscarriage (which is technically called an "abortion"—this word in medical discussions has no illegal overtones as it frequently has in lay connotation).

Recent work indicates that perhaps as many as 60 to 80 per cent of all pregnancies may end prematurely, often in the first weeks. It is now understood that many congenital defects can take place, and it is considered to be nature's way of maintaining a healthy race.

By eliminating a new life well before it means too much to the parents, and certainly many months before birth, gross defects or deficiencies, both physical and mental, can be rectified by this normal and natural means. It has often been likened to nature's way of maintaining "quality control" of the human race.

Nature (and in effect, God) is trying to be kind. This avoids headaches and heartaches. Caring for physically and mentally abnormal children (and adults) is a major problem today. This is one way in which it may be checked, normally and naturally. Therefore, women undergoing a miscarriage should never be too upset. By considering the possible alternatives, they are invariably being done a favour by nature. Never forget this.

Duration of pregnancy (in weeks from the last menstrual period):	Length of Foetus (measured in cm from crown to rump):	Characteristics:
8	2.5	Nose, the external parts of the ears are identifiable, but lack detailed characteristics. The head is bent and rests on the chest.
12	9.0	The external parts of the ears show the main parts. The eyelids are present, but fused together. The external genitals are present, but individual sex characteristics have not appeared.
16	18.0	The external genitals indicate sex differences. The skin is a transparent red colour.
20	25.0	The skin is becoming opaque. Fine hair covers the body.
24	32.0	The eyelids have separated. The eyelashes and eyebrows are present. The skin is wrinkled.

Downloaded from Fountain of Knowledge Library

Downloaded from Fountain of Knowledge Library

Chapter Twelve:

Baby Arrives!

The most exciting event in the life of any woman is the actual birth of her baby.

So, day by day, the pregnancy advances. The outward physical signs develop. The woman suddenly discovers her periods have ceased, and she develops the typical indications of pregnancy.

Development in the early weeks is rapid. Cells continue to divide quickly. The vital internal organs of the new life take shape, and soon the heart and the blood-vessel system are in operation.

Movements occur soon after, and this is termed the time of quickening. Sensible women have long since checked-in with the doctor and are now taking the usual steps and precautions that will guarantee them and their developing baby every chance of a safe journey through the prenatal period.

Pregnancy is commonly divided into three segments. These are termed "trimesters," and each trimester is one-third of the total duration of the pregnancy, in other words, about thirteen weeks.

It is simply an arbitrary subdivision worked out for ease in describing the events that take place during the various sections of the pregnancy interval.

During the final segment of pregnancy, the foetus increases mainly in weight. Legally, the foetus is alive or "viable" when it reaches the age of twenty-eight weeks. But it is most unlikely it would survive if born at this stage.

For practical purposes, it must reach the age of thirty-six weeks, and even then, it will be premature and underweight. However, under certain pressing circumstances, when its life is endangered by complications, every effort is made to reach the thirty-six or thirty-seventh week before delivery is contemplated. Every day beyond this increases its chances of survival.

However, for the average baby (which equals at least 85 per cent of the total number born, and will most likely include yours), the average duration of pregnancy is 280 days (from the last menstrual period). This equals nine calendar months.

For many weeks, and indeed many months before this anticipated date (termed the E.D.C.—estimated date of confinement), painless contractions of the womb commence. These may be felt if the hand is placed lightly over the pregnant abdomen. These take place especially at night, and may occur every few hours. This is termed "pre-labour," and is aimed at preparing the womb for the actual onset of true labour.

True Labour

Finally, as the important hour approaches, true labour actually sets in.

Downloaded from Fountain of Knowledge Library

This is often heralded by one or more events:

- (1) Regular, painful contractions occur in the abdomen.
- (2) There is a sudden "show." This means a jellylike, blood-stained plug of material is discharged from the vagina. (This is the "plug" that has sealed the cervical canal, the narrow duct leading from the vagina into the womb itself.) Now that delivery is imminent, the canal is unsealed and made ready for the exit of the baby.
- (3) Appearance of fluid. This is called the "breaking of the waters." It means the sealed bag of fluid in which the baby has been situated throughout pregnancy has burst, and the fluid is now flowing out via the vaginal canal. This may or may not occur at this stage. Indeed it may not occur until the actual birth is imminent. It varies.

With any of these signs, the mother is aware that the time of delivery is very close. It is a sign that she had better get her packed bag in hand and go to the hospital.

The abdominal pains quickly become more marked and more rhythmical and more uncomfortable.

Labour is traditionally divided into three stages. Each has certain characteristic events that take place.

THE FIRST STAGE OF LABOUR

This commences with the events already mentioned. In women having their first baby (called *primigravidae)* it lasts for about fourteen hours. In women who have previously reproduced the period is much less, averaging about seven hours.

At first, the action is fairly subdued. But with the passage of time, activity becomes much more marked. Toward the end of the first stage of labour, pains (which really mean uterine contractions) are coming at three-to five-minute intervals, and they last sixty to ninety seconds each. They are more and more forceful as time progresses, and toward the end of the first stage, the membranes usually rupture (if this has not already taken place). This means much fluid from the amniotic sac spills out from the vagina. This is a perfectly normal occurrence.

During the first stage, the cervical canal, the passage that leads from the inner part of the womb to the exterior of the womb, dilates to allow the baby to escape. When the canal is fully dilated, the baby is about to be born. The mother automatically prepares for the second phase of the procedure of birth.

THE SECOND STAGE OF LABOUR

This is the "expulsive stage," and culminates in the birth of the infant. It lasts from the moment the canal is fully dilated until the baby has been completely delivered.

The mother is gripped with an intense desire to "bear down," and this she does with stoicism and determination. The "pains" continue at regular intervals and are intense. She takes short sharp breaths, holds these with each contraction, and contracts her abdominal muscles and diaphragm in an effort to help the baby find its way down the vaginal canal. She perspires and grunts as the expulsive efforts are continued. It is hard work, and has been correctly named "labour."

While concentration is made to contract the upper muscles, the lower pelvic muscles are in a more relaxed attitude. This allows them to dilate to accommodate the baby's oncoming head.

Women who have trained beforehand in the skill of relaxation (also termed "psycho-prophylaxis") can do much to help themselves during this enervating period. By using the stimulation of the uterine contractions as a self-starter, they can motivate themselves into greater activity in helping the correct muscles contract (or relax), and this, in turn, assists the birth. Simultaneously, they find that the appreciation of pain is much less when their time and attention is taken up in this pre-trained manner. It can do much to assist both the patient and those in attendance.

At last the baby's head appears between the lips of the vagina. Usually the back of the head is the first part to appear. This is termed the occiput. With each expulsive force, an increasing amount of occiput appears. Finally the obstetrician takes over management, and firmly grasping the head, gently delivers the infant.

At this stage, depending on the attitude of the mother and the doctor, anaesthesia may be administered, although some women prefer not to accept this.

With a few deft movements, the infant is delivered, but is still attached to the mother via the umbilical cord. The doctor holds the baby up carefully by the lower limbs, and within moments the baby gives a few lusty cries as air is sucked into his lungs, and a new way of life suddenly takes place. Often the first tentative cries are followed by many more very loud yells. It is incredible how rapidly he seems to adjust himself to his new environment!

Downloaded from Fountain of Knowledge Library

At this point, the second stage of labour is over. Baby is born, and a new life has entered the world scene.

THE THIRD STAGE OF LABOUR

The third stage extends from the moment the baby is born until the time the placenta and membranes (the "after-birth") are delivered.

Shortly after delivery of the infant, the contractions which have become quiescent recommence, although at a reduced capacity.

The womb is aware that its functions are not yet complete. The large meaty organ that has been the source of food for the developing infant all these months must now be eliminated. So, contractions resume, and during this time, the unwanted placenta and the membranes which have been the sac containing the baby are sheared off the uterine wall.

Finally, signs show that this is complete. Then the doctor gives the upper part of the womb a firm squeeze, and the material is expelled along the same tract as the baby. This is usually accompanied by 250-300 ml of blood. Almost as soon as this takes place the uterine muscle contracts, effectively sealing off the exposed blood-vessels which formed such an important part during the developmental stages.

Usually injections are administered which guarantee that the womb contracts, and to guard against unwanted additional blood loss.

By this time, the umbilical cord which has connected the baby to the placenta has been tied and cut. Baby has been checked generally. Any fluid present in his throat and windpipe has been removed by gentle suction. The cut end of the cord has been covered, his eyes lightly swabbed out to remove debris. He has been wrapped securely in a warm woollen blanket, and tucked into his cot.

But by this time, his mother is usually making sounds—such as, "What is it, a boy or a girl?" "Is he all right?" "Can I have a look at him?" "Oh! Isn't he just adorable!" and "Is that him crying?"

The words seldom vary much from these basic questions. Wanting to know if he is all right, and whether it is a boy or a girl are the two most commonly asked questions at this moment.

Many doctors, aware of the tremendously strong link between mother and child at this critical time, give the baby to the mother for a few minutes to nurse. The expression of maternal love and affection at this moment is the most awe-inspiring and heavenly that a human being can ever witness. It is maternal tenderness and devotion at its maximum. Few doctors and obstetricians and nursing sisters will deny this moment of wonderment, irrespective of the countless number of occasions it has been witnessed. The close early relationship between mother and baby is now referred to as "Bonding." Doctors believe the sooner this starts the better, and within minutes of birth is certainly a good time. It is also believed that many of the common adverse activities some growing children develop in time are due to a failure in adequate bonding in the very early years of life. So . . . make the most of those early days when baby is still very tiny.

Soon after, baby is returned to his cot and trundled off to the nursery. Meanwhile the mother is given a sponge. Clean clothes are put on, she is given a drink perhaps, for the labour has been hard and enervating. The bed is cleaned up, and soon after she is transferred back to the ward where she often slips into a pleasant, well-earned sleep.

Duration of Labour

Quite a few hours have elapsed since she left her room. In fact, summing up, this is approximately how the time is passed:

Stage of labour:	1st baby:	More than one:
First stage:	13 hours	7 hours
Second stage:	1 hour	½ hour
Third stage:	¼ hour	¼ hour

These figures, of course, are average, but they give an approximate guide as to what may be expected. Older women having their first baby, or women who are timid and apprehensive, or women having large babies, or those in which the baby is lying in an abnormal position, will often have longer labour. But this is not always the case either. It is a variable matter.

Labour can often be effectively reduced in women who take a sensible approach to the whole question. Being in good health helps too. Having confidence in the doctor and staff, being mentally composed and happy and well-adjusted, are also features which may make confinement a shorter and much more rewarding event.

Indeed, as more and more women are discovering, a sensible approach, and taking time and making efforts beforehand can often pay handsome dividends when the moment arrives and labour is underway.

In recent years, many fathers have been taking an increasing interest in the delivery of their off-spring. Many doctors also condone this attitude, and father is often provided with a

Downloaded from Fountain of Knowledge Library

theatre cap, gown and mask, and is present at the birth. In fact, it can often be an extremely emotive moment as the couple together experience the birth of their baby. When this is the first time, it is probably an even more momentous and tender occasion.

IN CONCLUSION:

Although this account of the story of pregnancy is the way it will happen to most women, all manner of variations are possible. Throughout the world, each country has its own individual differences. These are usually acquired over a period of years, and are used because doctors everywhere have their own particular sets of ideas in all phases of medicine. Although basically the same, and in line with medical teaching and practice in the modern Western world, certain differences are inevitable.

Today there is a widening belief that many babies have a better chance of starting off life more satisfactorily if they are "induced." For "induction of labour" is now a well-established principle and carried out in many Western hospitals.

It has sometimes been called a "doctor convenience" system. But this is not so. By preventing baby from going over his expected date, it is believed there is a reasonable reduction in perinatal mortality. In other words, the risk to baby is reduced.

The question of anaesthesia for the mother during labour also varies. In the United States, epidural anaesthesia is very popular. This means an injection is given low down in the spine, and this reduces pain throughout labour. Added amounts of the medication are given from time to time to maintain this freedom from pain.

In many other lands, such as Australia, New Zealand and Britain, this is used, but far less extensively. In fact, anaesthesia is used much less overall, and sometimes it is used only at the mother's request.

It seems that, in some places, more and more women are keen on relaxation methods, and this often reduces the desire or need for anaesthesia during labour. But in all hospitals, there is usually adequate access to both anaethesia and medication for the relief of pain should this be needed.

Similarly, throughout pregnancy, an enormous variation occurs in different places regarding the care of the expectant mother. In some centres, very modern techniques and sophisticated devices are readily available to check on all aspects, particularly if there is the risk of any abnormality.

Systems utilising ultrasound and cephalometry are used now in many centres. Elaborate techniques for foetal monitoring are available. Amniocentesis, removing fluid from the uterus during pregnancy and checking for cells, carrying out chromosomal studies, and checking for certain enzymes that predict with reasonable accuracy such disorders as spina bifida, Downs disease, etc., are carried out. Rh disorders can also be checked in this manner.

More and more hospitals have genetic investigation centres linked to them so that abnormalities in this area can be checked, and appropriate advice offered if the need arises.

This is all part of the very active growth of new ideas in the medical-obstetrical sphere. With time, more advances in technique will develop, along with methods that have not even been considered yet.

Overall Progress

But the overall picture is one of progress. Every effort is being made to ensure that the developing infant will have a safe passage and a safe arrival.

Greater efforts than ever before are being made to reduce further "perinatal" mortality—that means death of newborn infants. Maternal problems have been reduced markedly. Now the emphasis is on Junior.

So, if your obstetrician considers various procedures are desirable during your pregnancy, or during labour, he will suggest these if they are locally available.

It is in your best interest. Never forget this. He will be taking advantage of the latest available developments, and giving you the benefit of them.

Your baby has now been safely delivered. You are a happy mother. Your husband is delighted with the child you have presented to him.

Now, turn over the pages, and you'll find many answers to your next set of problems—Bringing up Junior.

Best wishes and congratulations again.

Downloaded from Fountain of Knowledge Library

SECTION 3:

baby days and the growing child

This section discusses baby from the time he arrives home from the hospital, until he is starting to grow up and develop into a happy, intelligent member of the family unit. It covers the chief problems that a mother may encounter, and it also talks about many factors that will not take place, but could. It is clearly set out in ready reference form, and a quick check of the list a few pages over will enable immediate reference to the topic sought.

Downloaded from Fountain of Knowledge Library

Baby days have arrived!

Reproducing is one thing. Caring for baby from that moment forth is another, as the first-time mother will be quick to discover.

More experienced "mums" will already be familiar with many of the problems and the pitfalls and the "risk areas." Just the same, every new baby is a little bit different from the one before. Junior number two (or three or four) will probably develop many of the same illnesses and problems that his predecessor(s) did. But it is quite likely he will run into entirely different troubles as well.

The difficulties are perhaps highest for mothers who are passing this way for the first time. To them, it is an entirely new experience. There are no yardsticks of comparison. They have their trepidations; they are a little uncertain.

"Is my baby seriously ill?" "Will little Johnny make it?" "Should I call the doctor, or will he get better with a few simple remedies and the help of nature?" "How does he compare with other little fellows the same age?" "What do *other* mothers do in cases like this?" "Am I panicking, or being sensible, calm and normal?"

Mothers, the young and the more mature, still ask these questions a thousand times a day. It doesn't matter where you live, what social or economic structure you are part of, what the name of the country happens to be, the same questions pop up with unfailing regularity.

Mothers have an inbuilt mechanism geared to safeguard their babies and growing children. This is natural, normal and maternal. It is nature's inbuilt "something" which is always present. In fact, it's not confined to humans. Take a quick look about in nature, and you will see the same phenomenon manifested.

God-given Attributes

Parental devotion (often to the point of extreme hardship, or occasionally to death) is one of those unfathomable features of life. In fact, it's one of those God-given attributes of motherhood, and it is just as well for the tiny, helpless offspring. It is just as valuable an asset in the years of childhood.

Without the protection of a mother, her love, her attention and presence at all times when needed, Junior would fare much worse in this wild scramble of a world, at a time when he needs this protection most of all. Fortunately, many mothers have a strong intuition for doing what they should in many moments of stress, anxiety or tension. It is probably a sixth sense, a natural instinct. But it is surprising how common sense springs to action when the need arises.

This section of your book is devoted to mothers everywhere. It is a carefully planned division aimed at giving mothers a quick-reference guide to help cope with many problems which may suddenly loom, and for which they might not know the immediate answer.

Coupled with the inbuilt system just mentioned, it should assist a great deal in coping with emergencies, or even with the more mundane everyday incidents that crop up in the life of a baby and youngster.

Everyday Problems

This section covers a large number of everyday problems. It also gives advice and expresses opinions on a wide range of baby problems and situations that face the developing child. From the point of view of simplicity, and quick reference, a fairly comprehensive list of the more common items has been selected. These have been arranged in alphabetical order.

Following this article is a quick-reference index. Simply by referring to this, you will find the page to which you can then turn. Here will be an outline of the problem, together with advice on what to do, or how to cope with it. Broad, general titles have been given, and it is a simple matter to find the item that is of concern.

With babies and growing children, a point to remember is that they are variable characters. As they are in the developing and growing stage, their systems have not settled down to a strict normality that characterises the adult. For this reason they are prone to running sudden temperatures. But often, just as a temperature will quickly rise, and baby may seem very ill, it may also come down again promptly with a minimum of treatment.

Use this section as a general guide. Always bear in mind that it is not a comprehensive replacement for your usual medical attendant's advice. If there is even any doubt about the health of your baby or child at any stage, do not hesitate to phone your doctor. In this manner, you will be assured of getting proper attention, tailor-made to the circumstances of the moment. Also, specific medication may be required, and this will be ordered at the time.

But, the general principles of therapy are outlined, and matters discussed that will give adequate background for many of the problems you may have to face.

It is essential that a sick child be adequately cared for. There is nothing worse than seeing a small baby or toddler being neglected. In this

Downloaded from Fountain of Knowledge Library

modern age, when there is a wealth of knowledge readily at hand, this should never occur. But, sad to say, it still does.

The majority of mothers are sensible, and do a wonderful job in caring for their children. Mother love, devotion and affection invariably shine through. This is a wonderful thing for the baby and Junior. It is one of his best safeguards for achieving the teens, and later adulthood, safe and sound.

checklist

Accidents 138
Allergies 140
Apgar scoring 140
Artificial feeding 140
Autistic child 141
Battered babies 141
Bed-wetting 142
Birthmarks 142
Bowel actions 143
Breast feeding 143
Burping 144
Chicken-pox 144
Circumcision 145
Colic 145
Congenital abnormalities 145
Constipation 146
Convulsions 146
Cot deaths 146
Cough 147
Cradle cap 148
Crying 148
Danger signs 149
Deafness 149
Dermatitis 149
Diarrhoea 150
Dummies 150
Dyslexia 150
Ear problems 151
Eczema 152
Electric blankets 152
Eyes—blocked ducts 152
Eyes—squint 153
Feeding problems 153
Fontanelle 154
Gastric infections 154
Growth patterns 155
Growth rates 155
Hair 156
Hare-lip 156
Heart disorders 157
Hernias 157
Hives 158
Hot weather 158
Hydrocoele 158
Immunisation 160
Impetigo 160
Infections 161
Jaundice 161
Kidney infections 161
Lactation 162
Laxatives 163
Length 163
Measles—ordinary 163
Measles—German (rubella) 164
Medicine 164
Mothercraft 167
Mumps 167
Napkins 168
Nappy rash 168
Overfeeding 169
Phenylketonuria 169
Poliomyelitis 169
Prickly heat rash 170
Prune juice 170
Questions 170
Respiratory problems 171
Ringworm 171
Rusks 171
School refusal 172
Smoking mothers 172
Solid foods 172
Spoiling 173
Sun-baths 174
Teats on bottles 174
Teething 174
Thrush 175
Thumb-sucking 176
Toilet training 176
Tongue tie 176
Tonsillitis 177
Toys 177
Travelling 177
Umbilical problems 179
Vitamin needs 179
Vomiting 179
Water 181
Weaning 182
Whooping-cough 182
X-cellent progress 183
X-rays 183
Yawning 184
Z-Z-Z-fast asleep 184

Downloaded from Fountain of Knowledge Library

Accidents,
Allergies,
Apgar Scoring,
Artificial Feeding,
Autistic Child

is for . . .

ACCIDENTS

Growing infants and young children are particularly prone to accidents. It is impossible for the most faithful parent to be watching her child for twenty-four hours a day. Certain risks are inevitable. But many accidents may be avoided. Do your best to train your child from the moment he learns to crawl. By instilling in his very responsive mind (and infants absorb information at an amazingly rapid rate) and by repetition, he will gradually learn to avoid the danger zones.

Here are some of the many spheres in which accidents can occur. The list covers only a few of the important items. A full list would involve an entire volume.

Suffocation. Tragedies from suffocation have occurred on innumerable occasions, and they continue. Small babies are often unable to extricate themselves from situations where their air supply is blocked or reduced.

Avoiding a pillow for the first twelve months is often recommended. Or using one through which breathing is possible, even when baby has his face buried deeply into it.

Friendly cats may be a menace, especially if they make a habit of jumping into baby's pram and nestling close to his face. This can be a disaster. A protective screen may be essential.

Plastic bags are dangerous and should never be left about where there are young children. Placed over the head they may be lethal. If you use them, store them securely away, or else knot them firmly so that they cannot be used in a dangerous manner.

Choking. The intake of food can be dangerous, and mealtimes may be special at-risk times. Never leave baby on his own when eating. He should never be given a bottle, propped up then left. Milk may slip down the windpipe and choke him. Bits of rusk, or hard pieces of food can similarly obstruct the airways. He needs your help on such occasions, and you must be there.

Peanuts are a well-recognised hazard, and there is no more worrying sight than young children laughing and playing and running about munching peanuts, one of the commonest causes of choking.

If one slips down the wrong way, tipping him upside down and slapping him on the back is recommended by many baby experts. Others claim you should get the patient immediately to a major hospital where full facilities are on hand to deal with these serious emergencies.

Often vomiting when food goes the wrong way can compound the problem.

Toys are often a hazard. Eyes from dolls, buttons, plastic bits from toys, pens, etc., can easily be shoved into the mouth and inhaled. Sucking whistles can often cause the movable part to be inhaled suddenly and without warning. Care as to the toys available is essential to avoid catastrophe.

Bath-time. Never leave a baby alone in a bath. It is possible for babies to drown in an inch of water! Let the phone ring on rather than leave your baby alone in the bathroom. Always put cold water in the bath before the hot. Severe scalding has happened too often when a toddler thought the water was the right temperature and it was too hot.

Swimming-pools. The affluent are often at greater risk than those less well-endowed economically. Backyard swimming-pools, now commonplace in many areas, can be death-traps. Pools must be adequately protected from exploring youngsters. Drownings have been more frequent in recent years as the numbers of pools proliferate.

Electrical dangers. Power-points have a morbid fascination for many toddlers. They shove things into the holes, hairpins, nails, screwdrivers. You name it, some child has tried it. Points should be fitted with protective plugs to prevent this. But the child must be taught that these devices are dangerous. After all, he may feel safe at home, but run into temptation at a neighbour's who has not gone to the same efforts at preventing accidents as you have.

Teach him to respect all electrical appliances. The greater the efforts you make, the more it will pay off. Little by little he will come to recognise the potential hazards, especially if he receives a mild radiator burn one day, or similar injury. But even these are best checked before they eventuate.

Pills and medicines. Here disaster stalks. Today many medicinal products are put up in such attractive colours they often resemble sweets. Child-proof medicine bottles, the ideal, are now being widely used. In areas where they are used, the poisoning rate has dropped dramatically.

Downloaded from Fountain of Knowledge Library

Place medicines in lockable cabinets well away from investigating juvenile hands. Teach the child they are dangerous. Current methods of blister packaging by some drug houses are commendable. Poisoning from simple aspirin is the most common!

Medicinal overdoses may be lethal. In recent years, numerous childhood deaths from ingesting the tri-cyclic anti-depressants have been reported.

Immediate action is essential if the child is believed to have taken large quantities of medicine. Vomiting should be encouraged. Fluid may be given. Syrup of ipecac is often effective and harmless. A bottle of this should be standard in every household where children live.

Cigarettes. Besides the potential harm cigarette smoke may do to young children by smoking parents, leaving cigarettes about may also be dangerous. Eating a cigarette may poison a small child. It has happened! Besides, there is the risk of burns or fire if he tries to emulate his absent parents.

Open heating systems. These have recorded numerous serious accidents and must be covered by protective devices. Open fires, radiators and any other source of heat may attract a child, but it can be dangerous if he gets too close or falls into it.

Protection from other children. Some older children resent the newcomer, and will deviously plan for his harm. It is so easy to get a pram on the move downhill when it is stationary with the safety catch in place. "Accidentally on purpose," one might say. If there is any doubt about the older members, never leave the baby in their safe-keeping. It may prove to be most unsafe.

Kitchen hazards. The family kitchen is no place for a child. Yet it may be necessary for him to spend a lot of time there with you. Never leave pans with handles jutting out—it is so easy to catch them. This may apply to you or the child, and scalding is a serious matter.

If you are transporting potentially hazardous things about the kitchen, always look to see where Junior is standing. Hot items are a special risk. Cooking with an infant at your feet can be very dangerous. Walking on him (or his hands or feet) is not the least of the dangers.

Poisonings. An amazing number of household items are potentially lethal to babies. Yet these are carelessly left around in many households. Bleaches, sink cleansers, and similar items are often left in places readily accessible to babies who have no idea as to their potential lethal nature.

Babies have died drinking "lemonade" from a soft-drink bottle, only to find out too late that it was filled with kerosene or some other lethal fluid. These should *never* be left within access of tiny, exploring hands.

Getting locked in. Children love to lock themselves or others up in confined spaces. Old refrigerators are a hazard, and dangers are being recorded regularly. Never leave about a disused fridge or cupboard, or anything else that may form a human coffin.

Slamming Doors. This may be a danger. Do not slam doors yourself, and train your child not to either. Glass may shatter and produce severe cuts and abrasions. Besides, somebody else may get involved in the sudden process.

Swings and outside diversions. Swings have produced numerous broken bones and fractured skulls. When they suddenly swing back and strike an infant, the results may be disastrous. So keep your child away from them, or watch him well until he has mastered the art of handling them himself and has the mental acumen to appreciate their dangers.

The Garage. Just as the kitchen is a potential trouble-spot, so the family garage is just as bad or even worse. Here material, bottles of fluid, sharp instruments and tools, poisons, tools with pointed ends, electrical devices (often connected) lie about unattended. There may be dangers with the car, with slamming doors (and catching fingers and toes). When backing the car out, make certain Junior is not out of sight in line with the moving vehicle. Deaths have occurred in this seemingly impossible situation.

The Car. With growing children, safety-belts are imperative, and tailor-made ones to fit are essential. Never let a child sit unprotected in the front passenger seat. A sudden stop may throw him against the dashboard so forcibly it can kill! Safety-catches on doors are a good idea. Remember, never leave a baby in a parked car. Sooner or later the sun will come around and the internal temperature may rise quickly. Suffocation and death can quickly occur as baby dehydrates.

Prompt attention. Whenever an accident takes place, prompt first-aid attention is imperative. Much of this is sheer common sense. But the section in this book dealing with first-aid measures will cover many of the problems set out in this heading. Refer to it as often as necessary, and always have it handy.

Downloaded from Fountain of Knowledge Library

All the other problems. This list sets out only a few of the more obvious ways in which baby and your growing child may hurt himself to varying degrees. By considering the daily routine of the child, you will discover a host of others. The important thing is to recognise that accidents may happen. Do all in your power to keep them to an absolute minimum.

ALLERGIES

Allergies are very common in small children. Just about every known symptom in babyhood has been attributed to an allergy but, of course, this is usually incorrect.

Some allergies are mild and do not produce much concern. But others can be serious, and affect the child for a long time.

The commonest in the first years of life are skin disorders, gastrointestinal upsets and a wheezy bronchitis. These are well known to many mothers.

Foods most likely to produce allergies are cow's milk, wheat (and products containing wheat), egg, and orange juice.

If the allergy symptoms persist, it is essential to try to have the specific cause tracked down. Then the product can be left out of the diet, and improvement will often follow.

Sometimes this may entail a major variation in food intake and eating habits which could persist for a long time.

For instance, if there is a true allergy to cow's milk, it may need to be replaced by another item, such as a soy milk product.

To make certain that only true cases of cow's milk allergy are treated with this different product, the Australian Department of Health makes soy formula available as a pharmaceutical benefit. But it is available only if the allergy has been definitely linked.

It must be shown that the symptoms (eczema, asthma or severe gastric upsets) are relieved when cow's milk is withdrawn, but recur when the cow's milk is recommenced.

Sensitivity to eggs is often a long-term affair. Reaction to egg white is more persistent than to yolk.

Fortunately many allergies disappear at the age of four to five years.

APGAR SCORING

A method commonly referred to as the "Apgar Score" is often carried out in hospital, and becomes part of baby's birth record. It is mentioned here because many mothers have heard about it and wonder what it is all about.

The score is made usually within one minute of delivery in the labour ward of the hospital. It covers the baby's breathing system, its heart and nervous reaction and muscle system.

It gives a rapid immediate appraisal of the infant's health, and the possible need for further action.

Several headings are considered, and a score of 0 or 1 or 2 is made. These scores are totalled, and the nearer the total comes to 10, the healthier baby is. The lower the score, the more likely problems are in store.

The doctor fills in the Apgar score along the following lines:

Apgar score:	0	1	2
Colour:	Blue, pale	Body pink, extremely blue	Completely pink
Respiratory effort:	Absent	Slow, irregular	Good, crying
Muscle tone:	Flaccid	Some flexion of extremities	Active motion
Reflex irritability:	No response	Grimace	Cry
Heart-rate:	Absent	Slow (below 100)	Over 100

Depending on the Apgar score, the doctor will take whatever action is necessary.

ARTIFICIAL FEEDING

If breast feeding is not practical, then baby may be fed artificially. This is in the form of cow's milk, either straight or made up from various commercial forms.

According to some experts: "Undiluted cow's milk is the substitute for breast milk, and it has been shown that the majority of full-term, healthy infants can be fed undiluted cow's milk from the first few weeks of life, provided extra water is given in hot weather."

In the early weeks of life, cow's milk is often diluted with water. This reduces the protein content. The calorie content is then built up to normal by the addition of lactose.

Other experts believe fresh cow's milk is unsuitable, and that modified dried milks are much more suitable, keep better, are easier to prepare, and are more like human milk.

Many commercial products are available. They are of three main types: Fresh pasteurised bottle milk, evaporated canned milk (this must be diluted with water to equal fresh milk); full-cream dried milk (this must be mixed with water to equal fresh milk).

Cow's milk is notoriously deficient in vitamin C. So it is essential to provide an extra amount. Fresh orange juice is the simplest way. Rose-hip syrup is another.

Downloaded from Fountain of Knowledge Library

Many commercial milk formulas for babies are available—both liquid and powder—with added vitamin supplements included.

Irrespective of the type of milk used, baby is best fed "on demand." He is often the best guide as to how much milk he needs, and how often. Make sure enough milk is provided each feed. A simple rule is to make sure a little is left over. If he is still hungry after the first bottle, offer him a second.

AUTISTIC CHILD

This is an uncommon mental condition, but more and more attention is being paid to autism as the community becomes increasingly aware of its existence.

It is a mental disorder rather than a physical one, and the cause is at present unknown. It is more likely there are several causes, each interacting.

The autistic child lives in a world of his own. He is seemingly unresponsive to outside interests, and appears to reject the company and companionship of others, even those close to him, such as his mother.

He is aloof and indifferent, and treats others as remote objects. He even treats parts of his own body in a similar fashion. He is different from the average baby who adores company, and reacts in a happy delighted manner.

He often learns basic skills, but seldom uses these to communicate with others. For example, even after walking, he makes little effort to approach his parents or to associate closely with anybody. He seldom bothers to communicate with other children and indeed exercises no sense of interest in them.

Being unable to communicate normally, speech is usually affected. Indeed, he may not learn to speak, or may invent his own strange jargon.

Many autistics are quite intelligent in their own strange way. But the odd behaviour makes it difficult for them to use whatever talents they have. Others are mentally handicapped.

Long-term education by trained teachers who are prepared to spend an enormous amount of time and effort offers the only hope.

b is for . . .

Battered Babies,
Bed-Wetting,
Birthmarks,
Bowel Actions,
Breast Feeding,
Burping

BATTERED BABIES

In recent years this situation has become more prominent in the community. It also goes by the name "non-accidental injury to children."

As the name implies, babies or young children suffer injury that has not resulted from a fall or other injury sustained in the usual accidental manner. The bruises, fractures, lacerations or other injuries have been inflicted purposely, usually by a parent. The condition seems to be increasing in frequency, and may be a sad reflection on the high pace of living in this modern world.

Doctors will suspect it when mothers repeatedly bring their small child with allegedly accidental injuries. An astute doctor will soon pick up the thread, and will gently probe until he finds the true reason. Frequently the mothers come from places that are overcrowded, and

Downloaded from Fountain of Knowledge Library

where noise and poor facilities are the rule. Reduced socio-economic conditions are common, and the distraught mother simply cannot cope.

So often her own inadequacies are reflected in her treatment of her infant—often when she is at her wits' end. But it often occurs with the affluent and in those who have all they need in this world, indicating that it is not always a condition of the less fortunate members of the community.

Parental neglect when the mother herself was an infant has often been cited as a cause. These parents need psychological counselling and as much social support as possible. The doctor can often initiate this, and parents in this category should seek help urgently before a more serious battering occurs.

BED-WETTING

Most infants have learnt to control their bladders by the age of three years, or four at the most. However, many still continue to wet the bed at night. Sometimes infections or medical reasons may be the cause. But even when these are checked by the doctor and found to be all right, the problems may continue. Nearly every child will ultimately learn to control his bedtime habits, and in the majority of cases it is really simply a matter of time. However, there are adults in the eighteen-to-twenty-year bracket who are still chronic bed-wetters.

Most children wet the bed from the start. However, others may have become dry, then suffered an upsurge. This can often be tracked down to some emotional factor, such as the birth of a new baby, change of home, or some other important psychological factor in the infant's life.

Many efforts and schemes have been tried to cure the bed-wetter. Accepting the situation and not scolding the child on "wet" nights is recommended. Use of a calendar on which dry nights are encircled with a bright red pencil (by the child) often helps.

Setting the alarm every two hours during the day to that he makes regular trips to the toilet for urination often gets him into a routine. The interval may be increased, and often this results in dry beds at night.

The idea that the child is being naughty or doing wrong will never help the problem. A family of medicines called the "Tri-cyclic anti-depressants" are sometimes used by doctors to assist in a cure. A dose is given at night, and it appears to help in some cases.

Buzzers and alarm systems, particularly with older children, are claimed to give about the highest success score of any form of therapy. A buzzer rings when the bed is wet. This wakes the child. Very soon he develops a reflex and wakes up before the buzzer sounds and while the bed is still dry. He can then empty his bladder in the normal manner. These devices are often available on hire from medical supply companies.

Keeping the worry factor as low as possible is the surest way of achieving success in the long term. Tensions, anxieties, fears and phobias will do nothing to help the child, already over-anxious about his problem.

If there are domestic situations that can be corrected, then attend to these promptly. Any crises (such as a new baby) should receive attention. Let the young child know that he is not forgotten and is not being replaced. Often this reassurance will eliminate the upsurge of his problem.

Nearly every case is self-limiting, one way or another. Each passing year is a little closer to this time, whether treatment is undertaken or not.

BIRTHMARKS

Many babies have birthmarks. Sometimes these are present at birth. Others do not develop until several weeks have elapsed.

Many mothers are upset if they see birthmarks on baby's skin. Fortunately, in the majority of cases, there is no need for apprehension. Many tend to disappear in time. There is often no need to undergo any form of treatment.

Perhaps the commonest form of birthmark is one that occurs on the scalp, the back of the neck or lower part of the head. It may occur on an eyelid or near the bridge of the nose. It will often fade during the weeks following the confinement.

Birthmarks are often referred to technically as "angiomas."

Sometimes they may be extensive. They are frequently referred to as a "port-wine stain" (technically a diffuse capillary angioma). They may tend to fade as time passes, but many tend to remain. As the child gets older, the only treatment of benefit may be the skilled use of various masking applications.

Another sort of angioma is the "capillary-cavernous" type. These often start to grow a few weeks after birth. They can enlarge quite quickly, and the parent may be alarmed. However, the majority suddenly stop growing. They then tend to become smaller and smaller.

Downloaded from Fountain of Knowledge Library

Most fade away completely, leaving no scar or trace and no discolouration. It is best to leave them alone. Common moles are usually best left alone, too.

BOWEL ACTIONS

Many mothers develop a "bowel phobia" with their babies. Certainly, normal bowel actions are the ideal. But the range of what is normal can vary considerably.

Some babies have a bowel action after each feed. Others may not even have one action a day.

Normally, the bowel material is yellow and has the consistency of paste. Variations in the baby's state of health can vary this appearance.

Bowel actions of artificially fed babies are often more offensive than those of breast-fed babies. The addition of sugar to the artificially prepared feeds tends to make actions looser and more frequent.

If the actions are greatly increased in number and become quite fluid in consistency, then baby has diarrhoea, and may need special attention.

However, this can often be associated with other important symptoms which will be discussed under "diarrhoea" and "Gastric Infections."

Sometimes if baby has constipation, the bowel actions will be infrequent (see "Constipation"). They may cause distress when he is passing them, for the hard nature of the material can produce discomfort and maybe pain (see "Laxatives").

Sometimes the bowel actions may be green, frothy, very offensive or contain abnormal products, such as mucus (a slimy jellylike material), or even blood. These definitely warrant medical attention.

BREAST FEEDING

"Breast-fed babies are the best-fed babies." This old-time slogan still holds true. Unfortunately, many mothers believe this is too time-consuming, or can't be bothered.

But medical history has proved beyond doubt this is by far the best manner in which to feed an

Downloaded from Fountain of Knowledge Library

infant. It is certainly worth a trial, irrespective of how one feels about it to start with.

There are many factors supporting breast feeding, such as:

- Breast milk is readily available. The formula is right (no adding this and that); the temperature is always correct. No heating, no refrigeration is necessary.
- It is hygienic. There is no problem with storing, or contamination, a hazard in many homes especially in summer months.
- Breast milk contains valuable antibodies which give the baby added protection. Gastric upsets and many other problems are not so likely when baby has this type of food.
- The mere suckling by baby stimulates the womb to contract. This helps it return to its normal size in the weeks following the confinement.
- It is the ideal form of feeding for a baby who may be "allergic." Indeed, some babies are extremely sensitive to other milk products (cow's milk allergy can be a major problem).
- It may take a little extra time to establish, but there is a definite saving in time and money after the system has become established. It eliminates the constant sterilising problems associated with bottles. Long-term, it is far more economical.
- It forms a close bond between mother and baby. Psychologically this can be very important. Baby is not missing out. He is getting the fullest possible share of mother's love and attention.

Sometimes, of course, conditions make it impracticable to breast feed. The mother may be absolutely against the idea. There may be maternal problems, such as mental depression (which sometimes follows a confinement). There may be nipple difficulties or breast infections. Baby may have his own problems, such as prematurity, or birth difficulties.

No elaborate prenatal needs are necessary for breast feeding. Additional iron is often advised. The mother does not have to drink milk copiously if she does not care for it. Her milk will be manufactured from other components in her system.

Washing the hands with soap and water, and cleansing the nipples is the usual preparation for breast feeding sessions. Most women prefer to sit up, but some find lying on the right side preferable.

It may take several days for the regular feeding pattern to become established. But shortly, three to four hourly feeding will set in.

Baby gets 90 per cent of his milk in the first seven minutes. Generally ten minutes on each side is adequate. This leaves time for burping.

BURPING

With the vigorous sucking that accompanies feeding, most babies swallow a lot of air. This accumulates in the stomach with food.

Unless this is eliminated at the end of the feed, it can produce considerable discomfort for baby. Inadequate burping can produce much grizzling and crying later in the day.

It is customary to "burp" baby as soon as he has finished his feed. When he is breast fed, it is worth spending a few minutes after each feed to help him eliminate the wind from his stomach.

The simplest way is to place him against the body so he reclines over the shoulder. His back is then patted gently, or massaged in a circular manner.

This position allows the air in the stomach to rise to the surface. Usually with a few loud noises, the air regurgitates through the valve that connects the food-pipe (oesophagus) with the stomach. Baby gives a nice loud burp, and the air escapes. He may give several burps.

Chicken-Pox,
Circumcision,
Colic,
Congenital Abnormalities,
Constipation,
Convulsions,
Cot Deaths,
Cough,
Cradle Cap,
Crying

C is for . . .

CHICKEN-POX

This is one of the commonest infectious diseases of childhood. It is very prevalent in the first ten years of life. It is caused by droplet infection, and there is an incubation period of two weeks. The child is infectious from just before the spots appear, until the last scab has fallen off.

The virus is related to the one causing shingles (herpes zoster) in adults. In fact, adult herpes is believed to be a reactivation of childhood chicken-pox that has lain dormant in the system for many years.

Downloaded from Fountain of Knowledge Library

Generalised symptoms are rare, although the child may feel off-colour for a few days before the onset of the spots. They appear as pink marks, which soon develop into a small blister. They come in successive crops over three to four days. The face is affected commonly, then the trunk, and the extremities least of all.

Many cases are very mild, and will only reveal a few blisters after close scrutiny. Others have blisters everywhere, including the scalp, nostrils, ears, and in the mouth. Here they cause discomfort, and eating is difficult for a few days.

Complications are rare. The blisters are very itchy, may be scratched and so become infected. Simple bathing with very weak Condy's crystals solution (make water faint pink only) helps reduce infections. (This stains receptacles, so be careful, especially with baths.)

Sometimes soothing lotions with a calamine base help reduce irritation. Keep fingernails cut short to check scratching! If around the nappy area on babies, leaving the nappies off for prolonged periods helps to keep them from becoming soggy and infected.

CIRCUMCISION

At one time, it was customary for nearly every Australian baby boy to be circumcised.

However, in the past few years, many people have been taking a hard second look at the procedure. Many Europeans do not have their sons circumcised. With increasing numbers of new arrivals in this country, their ideas are being assimilated or given a hearing.

Many paediatricians are asking themselves just why circumcision is done. The idea that it is essential to hygiene is not always tenable. Using common sense and normal cleanliness, there is no valid reason, many believe, for operating and removing a part of the body which nature must have placed there for a purpose.

On April 24, 1971, the Australian Paediatric Society recommended: "That the newborn male infant should not, as a routine, be circumcised." (*Medical Journal of Australia*, 22.5.72). The *Journal* went on to say: "Routine neo-natal circumcision is founded partly on tradition and partly on a misunderstanding of normal anatomy. It is hardly ever necessary in infancy and seldom in later life. Its use as a routine measure cannot be justified."

However, the decision is up to the parents and about 50-50 is the figure. The doctor will comply with the parents' wishes. It is often recommended that males of the same family be treated identically to prevent social and psychological hang-ups occurring later on.

COLIC

The baby with colic is in the one-to-four-months-old age group. He tends to cry often and vigorously, as if prompted by recurring bouts of abdominal pain. His general appearance indicates he is making excellent progress physically, and there is usually no underlying organic disease present.

Of course, many babies will cry without being a true "colic syndrome" baby. Lack of attention is a common cause; thirst or faulty clothing in hot weather, a desire to suck, can cause crying bouts in some babies.

Other causes can be faults with feeding.

Baby's diet may be inadequate. There may be too little, or the consistency may be nutritionally inadequate. He may be ready for solids, but these have not been included in his diet. Sticking slavishly to a feeding schedule can also produce problems.

Faults in feeding technique can be a potent producer of colic. Perhaps posture is incorrect. Baby may be getting a flood of milk and the flow is such that he cannot cope.

He may be getting inadequate amounts either from breast or bottle. The teat may be at fault, allowing too rapid or too small a flow.

Air swallowed during feeding is a common cause of colic. Air vies with milk for space in the stomach. It may produce a feeling of satiety, when in fact the baby has not really had enough to eat. He will become hungry much sooner than normal, and will give vent to his discomfort and unhappiness.

CONGENITAL ABNORMALITIES

Fortunately, since the thalidomide tragedies of a few years back, serious congenital problems are tending to decrease.

Blanket advice is now given to women: No drugs of any description should be taken during the first three months of pregnancy, unless on the specific instructions of the doctor. This includes everything, even simple aspirin.

Drugs can have a very adverse effect on the developing infant at the time when his vital organs are being formed, which is during the first twelve weeks. Intending mothers must adhere to this advice to avoid problems later on.

However, there are many other things which can produce anomalies during pregnancy. It is well known that rubella (German measles) can

Downloaded from Fountain of Knowledge Library

produce outstanding foetal disorders of development.

Therefore, any pregnant woman contacting or contracting rubella must seek immediate professional advice. Tests will show if she is safe or vulnerable. Today, legal termination of pregnancy is often recommended if the baby is obviously at risk.

Other viral infections in early pregnancy are possible producers of foetal problems. The mother-to-be should make every attempt to keep free from germs and infections during the vital early weeks.

Smoking in pregnancy is well known to produce problems in the new-born. Smoking should be given up entirely during pregnancy and preferably in the months following confinement. Best of all, give it up altogether.

Alcohol is also a severe cause of congenital abnormalities and should not be taken during pregnancy. The foetal alcohol syndrome (FAS) is a potent cause of mental retardation, physical defects and premature death.

If abnormalities still occur and a child is born with some disability, much can now be offered in the expert centres in the major capital cities. The family doctor is a valuable guide in these cases.

CONSTIPATION

Usually the baby will have one soft bowel action a day. But this can vary without serious disorders being present.

Breast-fed babies are not so likely to have constipation worries as bottle-fed ones, whose stools tend to be hard and dry.

Many cases of constipation are temporary, and require little treatment. However, as the causes vary, so does treatment.

Often inadequate fluids will produce constipation. If baby has an infection, such as a respiratory tract or other bacterial or viral infection, he generally loses a lot of fluid from perspiration. So there is less in the bowel, and the actions become firm.

It is common for hard firm stools to over-distend the anal opening. This can produce a tiny tear or "fissure," which can make subsequent bowel actions very painful. In fact, it will aggravate the condition, for baby will tend to hold back to avoid further discomfort. The fissure can often be seen. Applying a local anaesthetic cream or ointment just before a bowel action will often give relief. Giving a mild laxative until the tear is healed is a good idea too (see "Laxatives").

Some abnormalities can produce constipation. Therefore, with any bowel abnormality that persists, proper medical attention is wise. Abnormalities can be discovered and corrected if necessary.

If constipation produces symptoms, such as pain or soiling, it is necessary to have treatment, possibly for some time, and proper supervision is needed. The use of laxatives or suppositories for weeks or months may be necessary, but this treatment must be ordered and supervised by the doctor.

CONVULSIONS

Many children will have a convulsion during their early years. In fact, about 5 per cent have one or more bouts, usually between the ages of six months and four years. They become much rarer as the child grows, and after age six are fairly uncommon.

The majority of convulsions are due to mild infections producing elevated temperatures. Indeed, babies tend to swing quickly from a normal to a feverish temperature. The brain can become temporarily overheated. In susceptible cases, this can lead to a convulsion.

Fortunately, only about five cases out of every hundred of those having one or more fits in babyhood have any problems in later adult life.

Most convulsions are self-limiting, and the infant comes to no harm.

However, it is a very frightening sight, especially when seen in a baby for the first time.

The best procedure is to lay baby on his side, and gently push the jaw forward. Trying to open the mouth with pegs or padded spoon may assist in keeping the airway open. But it can be difficult; care must be taken not to injure the child. Some doctors now recommend against this procedure. Never use force.

Some people find sponging baby with a cold washer helpful. It may lessen the fever and so minimise the period of convulsion.

Recurring convulsions need expert investigation. Even a simple one is best checked by the doctor, and treatment for the underlying cause begun.

COT DEATHS (Sudden Unexpected Death in Infancy)

In recent years an increasing number of young children are dying suddenly from a condition of unknown cause colloquially referred to as "Cot Deaths." It now goes by the long medical name of "Sudden Unexpected Death in Infancy

Downloaded from Fountain of Knowledge Library

Syndrome," or "Sudden Infant Death Syndrome" (SIDS for short).

It usually occurs during the first few months of life.

Baby is tucked into his nice warm cot, perfectly healthy to all appearance. But in the morning, he is dead! There is no sign of struggle, no apparent indication as to the reason. Generally there is not even a suggestion that he has moved during the night. It seems that he has just ceased to breathe. He has been in his usual room with the usual surroundings, and with the temperature the same. This discovery is a horrifying experience for any parent. But it is a tragedy for which there is no apparent answer.

It usually casts no reflection on the parents, or their care, attention or love and affection for their baby.

An enormous amount of research has been carried out over the past few years. This is still being actively followed in many countries. Many things have been suggested as the cause, but no single factor seems to bear the brunt of blame for all cases.

Allergies have been suggested, and the well-known house-dust mite which is a potent problem of childhood allergies and asthma has been blamed following many investigations.

Viral infections suddenly occurring in overwhelming force have also been suggested on numerous occasions. It seems this could be responsible in many instances.

Many doctors claim that cot-death babies are often placed in bassinets with the sides enclosed. The air baby exhales, they believe, accumulates in the enclosure, and so baby is unable to gain adequate oxygen in the air he breathes, it being filled with his own exhaled carbon dioxide. They recommend open-sided bassinets at all times.

Others claim it is more common in twins. Other ideas are that baby lacks adequate vitamin E levels in his blood. Aerosols, which are used in increasing amounts in Western communities, have been blamed.

Overstrength cow's milk, and excess sodium is a recent claim. One factor seems to come through with increasing emphasis, and that is the relative infrequency of cot deaths in breast-fed babies. Whether this is due to the unsuitability of cow's milk in some cases, or involves some complex allergy factor is unknown. But it is a big point in favour of breast feeding.

Inadequately burping baby after a feed, so allowing regurgitation of milk into his windpipe during the night when the wind is eventually brought up, has been cited as a cause. Its relation to serious diseases such as leukaemia, to oversensitive cardiac muscle fibres to heat, to cold, to a deprivation of magnesium, have all been quoted by "experts" from time to time.

Cot deaths probably have a multiple number of causes. The mother can only do her best. It is pointless sitting by baby's bed all night, fearing or waiting for the worst. A survey in Britain recently indicates the rate of occurrence is about one in 400 deaths a year as due to this cause.

Maintain baby in a room of even-temperature; avoid sudden temperature variations; keep the use of aerosols to a minimum; breast feed whenever possible and for as long as possible; reduce house dust to a minimum; and make sure baby's bassinet is well ventilated and open at the sides.

With present knowledge, this at least would help overcome some of the alleged causes of this very unhappy event.

If you do all these things, then you have at least done your very best.

COUGH

Respiratory tract infections are common throughout the community, and babies are also frequently affected. There is a special section later dealing with this (see "Respiratory Problems").

However, coughs are very common, and many simple remedies exist to help them. If there is any severe cough, the underlying infection of the breathing mechanism must be treated as well.

If the cough is producing a large amount of material, it is unwise to try to completely stop the cough mechanism. This is an automatic "reflex" mechanism of the body to rid poisons and toxins from the system, and so prevent them causing further illness.

A simple way to overcome a cough is to have the baby's room heated to a comfortable temperature. Most coughs occur in colder weather. A radiator or simple heating device can help reduce a severe cough. Cold air will aggravate it.

A simple, persistent, non-productive cough can often be relieved by having moist, warm air in the room. Even a kettle boiling can assist. Taking the child into the bathroom where there is lots of steam can be very soothing. In the middle of the night this can be reassuring (to the parents) and comforting (to baby). Turn hot and cold taps (or shower taps) on at the same time. Steam rapidly forms and the cough wanes. Also effective for croup.

Downloaded from Fountain of Knowledge Library

The responsibilities as well as the privileges of motherhood are great.

There are many simple cough remedies which tend to soothe inflamed air passages; some also contain a mild sedative. Pholcodine-based elixirs are helpful. Your doctor or clinic sister will advise you on a suitable mixture, and on the dosage.

CRADLE CAP

This is relatively common during the first months of life. It shows up as a brownish discolouration on the skin. It first appears on the scalp. But it can spread to the margins, and even on the ears, sides of the face, and elsewhere.

It is usually due to overproduction of the sebaceous glands in the skin (and these are more prolific on the scalp). Too much skin oil is produced. This tends to bank up and forms scaly crusts which adhere to the skin.

The simple way to treat the crusts is to apply olive oil at night. Then gently remove them with a dry towelling washer in the morning, using warm water.

Alternatively, liquid paraffin can be applied. This soaks into the affected parts, and loosens up the sheets of adherent firm material.

The whole area can then be washed, and the scaly plaques removed gently.

Often they tend to recur. But washing regularly and carefully will help to minimise this. Cleanliness at all times is necessary.

During the treatment it is best not to use brushes and combs and soap. Reserve these until the condition has disappeared. Sometimes the condition spreads to the body. Then, the application of creams which contain a small amount of tar can assist. However, if there is any doubt, it is wise to take baby along to the doctor for a check-up.

CRYING

Generally speaking, babies, as they become older, are placid in nature, and tend to be peaceful and happy. So, if baby starts crying for no obvious reason, there is usually a cause for it.

Babies usually cry when they are in pain or uncomfortable.

Wet or soiled nappies are a common cause of discomfort. Change baby as quickly as possible when nappies are wet. Change as quickly as possible after soiling. Apart from the discomfort, wet or soiled nappies, if left on, can produce irritation and skin rashes very easily.

A hungry baby will be an unhappy baby. Inadequate food, or food without enough

Downloaded from Fountain of Knowledge Library

nutritional value, will mean his stomach will feel empty, and the pangs of hunger will set in. What better way of sharing this unhappy state than to cry? It brings attention, and perhaps a bottle.

Wind accumulating in the stomach (the result of inadequate burping after the last feed) is notorious for producing internal discomfort. Wind can distend the bowel if it goes lower down the intestinal tract. A distended bowel produces pain. Conversely, part of the bowel may go into spasm, and this, too, is very uncomfortable. Proper burping is essential after every feed.

is for . . .

Danger Signs,
Deafness,
Dermatitis,
Diarrhoea,
Dummies,
Dyslexia

DANGER SIGNS

When baby is well and healthy, this is usually reflected by his appearance. He looks well. He is often rosy cheeked, looks well fed, is happy and contented, sleeps a reasonable amount of time each day, undisturbed.

Conversely, a baby that is not well usually indicates it. Babies haven't learnt the art of acting.

Therefore, if baby *looks* ill, it usually means he *is* ill. There are certain obvious signs that indicate that all is not well, and that baby is in need of medical attention.

FEVERS, whatever the cause, need some sort of treatment. Babies tend to "run temperatures" far more readily than adults. Their heat-regulating system has not yet developed. But any high temperature needs assistance, even a cool sponge.

FLUID LOSS, if persisting, definitely needs urgent medical assistance. Babies can dehydrate (lose fluid) at an alarming rate with persisting vomiting and/or diarrhoea. If this does not settle with simple home treatment (see "Diarrhoea") within a few hours, call the doctor. It is so easy for a baby to swing from being fit and well to perilously ill from fluid loss.

DISTRESS, if persisting, may need attention and professional help. A constantly crying baby is not natural.

BLEEDING from any area definitely needs professional skill and attention, both for diagnosis and treatment.

An UNCONSCIOUS baby must have immediate medical help.

Any severe or persisting BREATHING DIFFICULTY, must have a doctor's aid.

DEAFNESS

It is absolutely imperative that any deafness in a child be diagnosed as *early* as possible in life. If left untreated, not only will the child develop speaking problems, but his whole social, emotional, psychological and educational make-up can be severely disrupted.

Alert parents can often detect this abnormality in the first few months of life. The history of certain influences could make the child a special "risk" case, for example if there was rubella in early pregnancy (still a common cause).

A child that does not respond to loud noises, or to his mother's voice, even in very early life, should be suspect.

Do not delay in seeking expert attention. The chief centres for testing in Australia are the National Acoustic Laboratories, which are located in all capitals and in many larger cities.

The service given is excellent. If there is a hearing deficiency, the fitting and use of hearing-aids is advised. They are supplied by the Laboratories, on extremely satisfactory terms for everyone.

The earlier the child is fitted with a hearing-aid, the better. Any degree of normal hearing is capitalised on, and this is extended by artificial means. This will give the child a better-than-average chance of achieving a status in life similar to his contemporaries. In early life, this is very important.

Any child who is not talking reasonably well by the age of three is a definite suspect for impaired hearing, if this has not been previously noted.

DERMATITIS

Skin rashes and inflammations are common with babies. Many appear for simple reasons, such as in hot weather when the skin is aggravated by moisture or the rubbing of certain fabrics on the skin (see "Prickly Heat"). At other times, there is an actual infection present, such as staphylococcal infection (see "Impetigo"). Many cases occur of rashes about the buttock and genital region. This is commonly referred to as "Nappy Rash." (See this section for more detail.)

Many times, skin eruptions occur at the same time as some other process is going on, and the two seem related. For example, when baby is

Downloaded from Fountain of Knowledge Library

teething, rashes often appear. If there are internal infections, rashes can sometimes also occur.

If baby is allergic to something he has eaten or is contacting, hives (a common form of "urticaria") can set in (see "Hives"). These conditions often respond well to simple soothing creams and lotions and to anti-histamine mixtures.

When a skin inflammation occurs, often an underlying cause can be found if one seeks it. Teething, an infection, infrequent nappy changing, not letting baby have a good sunning minus his nappies, giving him food which obviously does not agree, are all potential troublemakers. Often the help of the doctor is needed to discover the cause.

Baby often responds well to simple creams and lotions. Zinc cream, alone or in conjunction with small amounts of tar, is very soothing and can settle down skin eruptions promptly. Sometimes zinc cream with added castor oil is effective.

DIARRHOEA

Diarrhoea is the passing of frequent fluid stools. There are many causes. Some are minor and the condition is transient. Others are very important and need prompt treatment.

The most important cause of all is gastroenteritis. This is an infection of the bowel. Large amounts of fluid are lost, both from perspiration as well as by the bowel. It needs medical attention quickly to avoid serious dehydration (see "Gastric Infections").

Other conditions can produce diarrhoea. Simple overfeeding is often rightfully blamed. The treatment for this is obvious—a reduced food intake.

Sometimes excessive amounts of sugar are added to baby's food. This can produce excessive fluid actions.

Infections are notorious for increasing bowel actions. Simple infections involving ears, throat, chest can all produce an increase in the frequency of bowel actions. Treatment is primarily aimed at curing the underlying cause.

During teething, many babies develop loose bowel actions. There is little that can be satisfactorily done to combat this. Generally it is temporary, and is self-curative as time passes. Excess dehydration does not often occur, but as with any increase in bowel frequency, it is essential to keep an eye out for this. Medical attention may be needed if baby is losing excess fluid.

The antibiotics, so effective in helping many infections, can often produce diarrhoea. Very rarely are antibiotics used in treating diarrhoea.

DUMMIES

Every expert has his own ideas about the use of dummies. Similarly, every parent is an expert.

A dummy may appear to be a good idea to keep baby quiet when obviously unhappy, or crying, or in minor distress.

A dummy is shaped like the nipple, and it is basically aimed to give similar satisfaction to normal suckling. Babies often like to suck and "play" with the nipple even after they have satisfied their appetite. It seems to give them a sense of security and inner happiness.

The idea is to transfer this from the human nipple to an artificial device, and similarly provide a source of comfort and contentment.

Many claim that if baby hasn't a dummy, he will manufacture some replacement item, such as his thumb (giving rise to thumb sucking), or his fist or fingers, or a bit of rag.

Those condemming dummies claim they are unhygienic, may carry bacteria and virus infections, and so predispose to infections of baby's system. It is impossible to keep a dummy permanently sterile, and they are often seen lying on the floor, with flies crawling over them.

It is possible to bring up children happily and normally without the use of dummies. It is also possible to bring them up so they do not become regular thumb-finger-sucking addicts. It is easy to withdraw gently the thumb or fingers from baby's mouth when he falls asleep.

DYSLEXIA

Dyslexia means a child is having difficulty in learning to read. He can see the printed word quite clearly, but to him it seems a confusing jumble of symbols which mean nothing to him.

Lots of children have early difficulties in learning to read. Insecurity, tensions and anxieties can aggravate this, even in the normal.

However, if your child seems to be particularly slow in this respect, or is eight years or older and is lacking in progress with reading, he may be dyslexic. Special tests may be necessary.

Discovering the dyslexic child can often be difficult, for it can be hard to pick him out with overcrowded classes and lack of personal contact which is the case in most schools today.

The child is often quite bright, and can express himself very well when speaking. But his writing

Downloaded from Fountain of Knowledge Library

is sometimes muddled, and letters reversed and confused. Alphabetical symbols with similar configuration are often exchanged, for example "b" and "d."

Often he is unfortunately labelled as being lazy, and not trying.

A child with this problem requires special teaching skills, even after recognition and diagnosis. Much harm may occur if this is not carried out, and it can have persisting psychological overtones.

He needs extra individual attention and sympathy from a teacher who is aware of these problems and is trained to handle them. Some teachers (called "remedial teachers") have undergone special training to assist these unfortunate children. Securing the assistance of one of these people is the best advice.

e is for . . .

Ear Problems.
Eczema.
Electric Blankets.
Eyes

EAR PROBLEMS

Perhaps the most common ear problem is the development of a sudden infection. This will produce a very painful ear, and may be heralded by an increased temperature, the child holding or pulling his ear, and after a day or two, reduced hearing capacity.

It frequently follows on from a simple head cold, with which there may have been much sneezing. The germs can quickly track up the Eustachian tube into the inner ear, and lodge there.

The doctor is a friend—don't hesitate to call him if you are uncertain about your child's health.

Downloaded from Fountain of Knowledge Library

Treatment of *any* ear infection is essential. If left, deafness (usually non-permanent, but it can last for some weeks) may occur. Also, there is the definite added risk that meningitis and more serious brain infections can follow.

Often a few drops of warm olive oil in the ear will help reduce the pain of an ear infection. But get prompt medical assistance. Antibiotics are usually necessary. Anti-pyretics are often given as well. Paracetamol elixir (consult label for dose) can help reduce elevated temperatures and pain.

Foreign bodies in the ears are common. Most are pushed there by the infant. An enormous range is possible (beads, dried peas, bits of plastic from toys, ends of pens, etc). These may remain there, or produce symptoms (deafness or infection) from their presence. Do not fiddle yourself. Unless it can be removed easily, see the doctor. He has special instruments, and can usually lift the foreign body out promptly without damaging the ear canal.

ECZEMA

This is quite common in small children. It is often called "baby (or infantile) eczema."

It tends to occur as localised areas of weeping skin. Usually a considerable amount of itch and irritation is present. So baby tends to scratch, and the more he scratches the worse it becomes. Further infections may occur with the scratching and introduction of germs. Face and scalp are common areas; so are knees and elbows (fronts and backs). Often there is a family history of asthma or other allergic problems.

Frequently eczema is associated with a dry skin (so may be worse during winter months); or the aggravating effect of certain materials (notably wool), lanoline, etc. Food is not often blamed as an aggravating cause, and baby's normal diet should be maintained unless specifically changed by the doctor.

Although relatively common in babyhood and childhood, this type of skin problem tends to lessen with advancing age. Fortunately, only about one in three (possibly less) ultimately develop other allergic manifestations like asthma and hay fever.

The less the areas are bathed the better. Soap, wool, lanoline should be kept away from all affected parts. Bandaging may be needed to stop scratching and aggravating the affected areas. Calamine lotion or zinc paste may be applied until the areas dry. Then zinc cream (with added tar—several products are available) may be used. Persisting cases need medical attention.

ELECTRIC BLANKETS

Electric blankets may be a hazard with small children, and extreme care in their use is recommended.

With the low price and general availability of these blankets, most families now use them. Generally there is little harm, for they conform to national standards and are safe.

But used with sick children, they may cause the sudden rise in temperatures which have been known to predispose to very high fevers and even convulsions.

A sick child is frequently overheated. The added warmth from an electric blanket can push this to higher and higher levels. This is more likely at night, when the child is asleep.

Never leave your child alone at night with an electric blanket turned on at any level but medium or low. As the night progresses, warmth is often automatically and naturally generated by the bedclothes.

Additional heat is often unnecessary.

This is a cautionary note, for greater numbers of cases are being reported where dangers have arisen.

Overheated bodies produce overheated brains. Convulsions, especially in the very young, may take place.

EYES—BLOCKED DUCTS

Baby's eyes are sensitive. So are the areas surrounding them.

A small canal runs from the inner corner of each eye into the nasal region. This conveys the tears when he cries.

However, baby may have a persistently watery eye. Tears spill over the lower lid and run down the face, rather than disappear into the nasal areas. Also, he may seem to be contracting recurring infections. The eyes may become red, with pus.

If the corners of the eye area (between nose and eye itself) are pressed, yellowish material will be seen to well up into the corner of the eye. This indicates the duct has blocked. This may be due to a fine bony membrane blocking the canal. Baby may have had this from birth. But it may also be due to a recurring simple infection of the canal itself.

Bathing the pus and debris away often is necessary. The condition is usually best checked by the doctor. He may order drops or an eye ointment. Applied as instructed, they will tend to check the infection (and any recurrences).

Downloaded from Fountain of Knowledge Library

Often the use of these simple materials will help the duct(s) clear automatically in due course.

However, if they continue to block persistently after simple measures have been given a good trial, the ducts may be "probed." The eye specialist does this, and an anaesthetic is needed. This usually clears the canals permanently, and recurrences seldom take place.

EYES—SQUINT

Squint (technically "strasbismus") is the condition colloquially (and cruelly) called "cross-eyes."

The condition is usually minor, and often hard to detect during early life. However, parents will finally notice that the visual axes of the eyes are not parallel.

Often the shape of the baby's facial features will give an incorrect impression of squint. Sometimes children with a broad flat base to the nose can give this impression.

It is very important that possible squint be checked early, and if present, that correct procedures be taken to correct it. Otherwise, the infant will tend to suppress vision from one eye automatically.

Each eye throws an impression on the sensitive retina at the back part of the eye. Therefore, two images occur. These are slightly different. But when they are fused into one image in the brain, the "third dimension" or "depth" factor becomes appreciated. This gives us the impression of space, and is vitally important in our everyday living. (Just close one eye and see how many false steps and moves you make in five minutes.)

If the two images are so different that they refuse to merge into one, it is possible to block out one image mentally. So the depth factor can be lost. If this persists, it may last into adulthood. Treatment by the eye specialist is essential if there is any likelihood of squint. Your doctor will check it first, then make any necessary referrals. Do not delay.

is for . . . Feeding Problems, Fontanelle

FEEDING PROBLEMS

It is worth bearing in mind that baby has a major job to undertake in the first few weeks of

"The best-fed baby is the breast-fed baby."

Downloaded from Fountain of Knowledge Library

his life. This relates to the way he gains his nutritional needs. Before birth, large vessels brought nutrition into his body through the umbilicus (later to become the scar of the navel).

But from the moment of birth, when these vessels are sealed off permanently, he must orientate himself to a new way of eating. His mouth starts to work, his digestive system to operate.

It may take some time for baby to become accustomed to taking food in this new form. Indeed, it is surprising how rapidly most infants can adjust to the new circumstances. If it seems to take a little time, do not panic. The fact that you get nervy, "up-tight" and irritable can readily be picked up by baby. It may aggravate problems, including his ability and interest in sucking and taking his food.

These days, most parents find a combination of "schedule feeding" (by the clock every four hours) and "demand feeding" the most convenient system. It is amazing how quickly baby will swing into a routine. It may take a few weeks to become firmly established, but when it happens, he usually settles down, and often becomes almost as regular as the clock.

Learn to be flexible. Do not stringently stick to arbitrary feeding times on every occasion. Adapt, and your problems will ease.

FONTANELLE

To make birth as simple as possible, nature has been very kind. The largest part of the baby to appear (and usually the first) is the head. It is essential, of course, that the head fits through the mother's bony pelvis.

For this reason, the bones of the head are relatively soft, and quite pliable at birth. The bones forming the skull are in several segments. Later on, they will grow, and finally join up (fuse). However, if the head is a tight fit at birth, the bones are able to move around, overlap, and even change shape.

Seeing a newborn baby who has experienced a difficult birth is common. Frequently his head is quite malshaped. But this is temporary, and merely reflects the versatility of this part of the human body to stress.

On top of the skull, where these bones come together, a fairly large hole occurs in the bone. This is referred to as the "fontanelle."

If you feel for it, you will always discover it in a new baby. As your fingers move over the firm skull bones, they will suddenly encounter a marked lessening of resistance. The part is soft. The skin of the scalp covers the hole. Underneath this are blood spaces, and under this again is the brain.

In years gone by when baby may have required a blood transfusion, it was often done via the "fontanelle." Do not be alarmed at feeling the fontanelle. It is perfectly normal.

g is for . . . Gastric Infections, Growth Patterns, Growth Rates

GASTRIC INFECTIONS

In years past, gastric infections constituted one of the most serious and alarming causes of death in early infancy. However, with modern methods of milk sterilisation and refrigeration, and with the elimination of many sources of infection in modern times, it is not as hazardous as it once was. But very great care is essential for any infection of the gastrointestinal system. This is commonly referred to as gastroenteritis.

Symptoms include a fever, nausea and vomiting, and the production of frequent, very loose stools.

However, it cannot be too strongly stressed that any vomiting or diarrhoea in a baby (especially twelve months of age or under) needs the prompt attention of the doctor if symptoms do not show signs of improving within a very short time (say twelve hours at most).

In summer, the invading germ is often "salmonella" or "shigella." Bowel actions are often associated with blood and jellylike material called mucus. Summer is the most likely time for gastroenteritis, for infection is rapidly spread by flies. Milk is a notorious medium for germs.

Gastrointestinal infections may be the most severe in the first year of life. This is the danger period. The big bogey with these infections is the danger of dehydration.

Small, frequent sips of cool water, or lemonade, or boiled water to which powdered glucose-D has been added, should be given. "Flat" lemonade is often suitable. Give every half to one hour. Vomiting and diarrhoea usually subside within twenty-four hours.

Sweetened condensed milk (one part in 16 parts of water) can then be given in greater amounts during the next 24 hours. This can then be reduced to one part in 12, and the following day to one part in eight.

Baby's normal feedings can usually begin the

Downloaded from Fountain of Knowledge Library

day following this, and his usual solids the day after this again.

If there is a sudden resurgence of the diarrhoea, there must be a discontinuation of ordinary feedings, and reversion made to the fluid feeds.

Dehydration is a big bogey, and a very real one. In Australia, babies still die because they have been left too long before expert help has been summoned.

Many moderate to severe cases need prompt hospital admission with specialised treatment to avert problems and possible death. If you cannot get your own doctor in a hurry, get the baby to hospital.

GROWTH PATTERNS:

Milestones In Development

Most babies reach important milestones in their development at approximately equal times. However, many situations can produce alterations. Every baby is an individual, and what affects one may not similarly affect another.

Many factors may produce variations. For example, infections can take their toll. Adequate nutrition, or lack of it, may be important. The degree of maturity at birth could play a significant part. Congenital abnormalities, particularly of the nervous system, or the muscle system, could be important to baby's future development.

. The general family pattern of development is frequently a factor. Tied in with this may be the quality of love, attention and maternal affection devoted to the baby, and the general stimulation provided by other members of the family.

Many standards of measurement have been devised by doctors. These are frequently

elaborate, but often they are not necessary, for they endeavour to make all babies fit a preconceived pattern, a set standard. They have their uses, and in certain circumstances, may be a valuable guide to the doctor.

The following list sets out the approximate milestones of development and the age at which these could be expected to take place in the average baby. They may be used as a general guide, but are not immovable, fixed points. Every baby is different. Use the list with this general thought in mind.

Age of Baby	Milestones of development
2 to 6 weeks	Baby smiles. He will follow objects with his eyes.
3 months	He supports his head well. He has an appreciation of his own hands.
4 months	He will reach for objects and place them in his mouth.
6-7 months	He sits without support. Is aware of strangers.
7 months	He will pass objects from one hand to the other.
8 months	He can now roll over, lying on his back, then onto the front, and vice versa.
9 months	He can now stand up, supporting himself by holding on to furniture. He uses the thumb and index finger to grab objects and pick them up.
10 months	Has mastered the ability to crawl.
12 months	He can now pull himself up to the standing position, and can walk with support.
15 months	Now able to walk on his own, unaided. His speech is still a jargon, but several words have probably been mastered.
2 years	Now he is using short sentences. He can help with his dressing and undressing. He can run, and kick a ball and do similar activities.

Downloaded from Fountain of Knowledge Library

GROWTH RATES

• **WEIGHT.** Baby's weight can vary a great deal. At birth, it may range from 2,500 g (5½ lb) to 4,500 g (10 lb).

At birth, the average weight for Australian males is 3,459 g (7 lb 10 oz). For average Australian females, it is 3,402 g (7 lb 8 oz). New Zealanders are approximately the same.

Baby rapidly puts on weight from the day of birth. By the fourth or fifth month, birth weight usually doubles. By the end of the first year, it has usually tripled.

• **LENGTH.** At birth, the average Australian male measures 51.8 cm (20.4 in). The figure for the average Australian female is 51.1 cm (20.1 in). This increases rapidly also, so that at the end of the first year, it has increased by about one half. The table below gives an indication of the average weights and lengths (heights) at various ages in the first twelve months of life.

Many Australian mothers take advantage of the government-run baby health centres where regular checks on baby's growth are made, and advice is given where deficiencies are evident. New Zealanders have similar facilities.

h is for . . .

Hair,
Hare-Lip,
Heart Disorders,
Hernias,
Hives,
Hot Weather,
Hydrocoele

HAIR

The amount of hair a baby has at birth varies enormously. Some are endowed with masses of black hair; in others the supply is skimpy.

It doesn't matter if there is very little or a great deal. In the first few weeks or months, much of the hair present at birth will come away, and new hairs will gradually appear.

Often baby will develop a bald patch on one side or other of his scalp. This may be due to the fact he sleeps for most of the time on one side.

The constant rubbing against the pillow acts as an abrasive, and so shears off the hair from the scalp.

Many mothers alternate the side baby sleeps on after feeds.

The nature of the hair seems to vary throughout life in many cases. Infants and children with straight hair may later develop wavy hair.

Hair colour is determined by the special cells in the hair root which impart the pigment.

This often tends to darken as the years advance. It is common to see a fair-haired child later become much darker.

Hair normally grows at the rate of 0.35 mm a day, or roughly one-half inch a month. In the human head, by adulthood, there are about 100,000 hairs; 50 to 100 drop out each day, normally.

But this means the hair bulbs are in the temporary "resting phases," and they start to grow after a period of weeks or months.

HARE-LIP

Facial abnormalities occur with a certain proportion of babies. These may be "cleft lip" (colloquially termed "hare-lip"); or "cleft palate," or a combination of the two at the one time, "cleft-lip and palate."

This means that, at the time of birth, there has been a defect of the lip and palate (the roof of the mouth) because the two sides, left and right, have failed to unite in a satisfactory manner before birth.

AUSTRALIAN INFANTS: Heights and Weights

Age	Average Weight		Average Height	
	Male	Female	Male	Female
Birth	3,459 g 7 lb 10 oz	3,402 g 7 lb 8 oz	51.8 cm 20.4 in	51.1 cm 20.1 in
3 months	6,435 g 14 lb 3 oz	5,954 g 13 lb 2 oz	60.7 cm 23.9 in	59.7 cm 23.5 in
6 months	8,704 g 19 lb 3 oz	8,051 g 17 lb 12 oz	68.3 cm 26.9 in	66.8 cm 26.3 in
12 months	11,028 g 24 lb 5 oz	10,319 g 22 lb 12 oz	77.0 cm 30.3 in	75.2 cm 29.6 in

Downloaded from Fountain of Knowledge Library

Fortunately, figures recently taken out in Western Australia (probably representative of the nation and New Zealand) indicate the problem is declining. It stands at about 1.73 cases for every 1,000 live births.

(It is believed that about another one in four die before birth, and so are still-born. Others may be involved in miscarriages during pregnancy.)

Expert attention is now available for babies born with these defects. The large capital cities have special "Maxillo-Facial Units" which care for them.

Any baby born with a disability of this nature may have special surgical work carried out which will give the best possible results.

Many Australian surgeons are now highly specialised in this skill, and can bring a reasonably high degree of normality where once a major persisting problem occurred.

Specialised attention is usually arranged from a very early age, and often the hospital or obstetrician and paediatrician attending will assist with subsequent arrangements.

HEART DISORDERS

Children can sometimes have heart disorders. They may be born with congenital defects in the structure of the heart, and these may produce symptoms.

Many infants have murmurs over the heart. Most of these are innocuous and are of no significance. They are often caused by the blood moving around in the hollow compartments of the heart. Frequently if they alter position, the murmur will disappear.

Sometimes, persisting murmurs may be due to structural deformities within the heart. There may be holes present too, in abnormal positions. These may allow blood to leak between the compartments in an unnatural manner. These are present in some from birth—they do not develop later on. However, many of these tend to close up without any treatment, and further interference later on is not necessary.

Today, in mild congenital situations, doctors frequently wait before taking action. Many parents desire immediate surgery to correct the abnormality, but with experience, it has been found this is not always in the best interest of the child. He should be treated normally, allowed what exercise he desires, and encouraged to live a normal life.

"Blue babies" have a more severe congenital abnormality. The blood from the veins mixes with blood from the arteries, and a bluish complexion occurs. Today, this condition is usually discovered early in life, and with modern surgical techniques, the outlook is generally very good.

Rheumatic Fever. This is a sensitivity reaction to an infection by the streptococcal germ. It frequently follows on ten to fourteen days after a severe throat infection with this germ.

Today, strep throats are usually treated promptly with penicillin, and this can effectively prevent the onset of rheumatic fever.

Fewer youngsters contract rheumatic fever these days due to the universal availability of penicillin. Fortunately the germ is still very responsive to it.

Those who do contract the disease may have to take penicillin in some form for some years. This may be by daily oral tablets, or an injection less frequently. Penicillin is safe and very effective, and generally has no adverse side-effects. The wide use of penicillin is the key reason why rheumatic fever is seen so rarely nowadays.

If it does take place, it is usually preceded by a strep sore throat. It usually strikes the large joints, the shoulders, elbows, wrists, hips, knees and ankles. It seems to prefer to flit from joint to joint, remaining two to three days before moving on. The child is ill and runs a high temperature.

It is essential that the child be under correct medical management, and the doctor must be consulted and his orders followed rigidly.

Rheumatic Heart Disease. This was very common in days gone by. But with the wide use of penicillin, it is reducing considerably. Even in those with rheumatic fever, the chances of its affecting the heart adversely are now also much less than in former times.

HERNIAS

A hernia is a protrusion of parts of the abdomen through apertures (that have not normally closed at birth) in the front wall of the abdomen. Hernias occur most commonly in two areas, the umbilical region (navel) and inguinal (groin) area.

Umbilical Hernia. Before birth, the baby was connected to the placenta (later the "after-birth") by the umbilical cord. Through this, large blood-vessels conveyed blood and food and oxygen to the developing infant. At birth, the cord is no longer needed. It is cut, and it later leaves only a scar known as the navel. However, the aperture through which the cord passed sometimes fails to close up immediately. Therefore, it is possible for the bowel and other

Downloaded from Fountain of Knowledge Library

abdominal organs to be pushed out through this hole.

One infant in six has an umbilical hernia. About 93 per cent close up on their own within the first twelve months after birth. The rest generally close by the age of four years, the remaining few usually by six years.

Dangers are rare and complications almost unknown. No treatment is needed. Sometimes, in older children, "strapping" is applied, or occasionally surgical repair may be suggested.

Inguinal Hernias. These occur in the groin through an aperture that invariably closes up during the first year of life.

Often part of the bowel can be pushed through the orifice into the hernial sac. In this way it is possible for it to get in, but not out again. So an "obstruction" to the bowel occurs. This may be serious and can constitute an emergency. So surgical repair is usually recommended for all inguinal hernias in infants.

HIVES

Urticaria is the name given to an irritating, red, raised, itchy skin condition which is often allergic in nature. A common form is hives. These red, raised patches may be excessively itchy.

Larger areas, or indeed extensive sheets of skin, may be involved. The margins are red, the whole region is prominently raised, and the central parts are white.

Urticaria is produced by the liberation of a chemical called "histamine" from cells of the body. These have been damaged by a foreign substance to which the body is sensitive.

So a "histamine reaction" takes place.

If the sensitising agent has only temporarily contacted the body, the reaction is short-lived. It tends to vanish in due course with or without treatment.

However, if the contact remains, the rash may become long-standing or "chronic."

An effort is usually made by the doctor to try to find out what is producing the allergy reaction. Sometimes it may be a new sort of food to which baby is sensitive. Eggs, chocolate, sea-foods, and wheat are common offenders; or it could be an aerosol spray. Sometimes medication is the cause, and penicillin is a fairly common troublemaker in this field. However, many other lines of medication have also been blamed in individual cases. This is a personal matter, and is usually specific for the individual.

Simple cases respond well to "anti-histamine" medication. This comes in elixir form (on a doctor's prescription usually). Also, an anti-itch cream may be applied to the area.

HOT WEATHER

Every summer, a major tragedy (one or more) occurs in nearly every big city. It's because some mothers are completely unaware that hot weather can produce special hazards for baby.

Babies do not have a very satisfactory heat-regulatory mechanism when they are young. It develops and improves as they grow older.

NEVER, under any circumstances, leave your baby alone in a parked motor-car. This can be (and has been) lethal. Although a car may be in the shade when you leave it, the sun moves quickly, and it can be in the full, direct heat of the fierce rays half an hour later. Some parents have left babies in cars for hours with all windows up and doors locked. Disaster is inevitable. In midsummer the inside of a motor-car in the sun can become almost as hot as an oven.

Dress baby sensibly in hot weather. Loose-fitting, light-weight garments are essential. Nappies alone are often adequate.

Put the bassinet or basket (or whatever he sleeps in) in a well-ventilated room in the cool part of the house, when the temperatures soar. The bathroom is usually the coolest. But avoid direct draughts, as a direct draught could cool him down too fast and allow a summer cold to get a foothold.

Much more fluid is essential in summer because baby will sweat a good deal. Cool, boiled water, or orange juice, with some salt and glucose added, is preferable. Frequent sponging is a good idea, if he is starting to get very warm.

Be very careful not to permit overexposure in the sun. Sunburn with tender baby skin is very simple to acquire. It is dangerous and can be extremely painful. Care at all times is essential, but even more so when the temperatures soar.

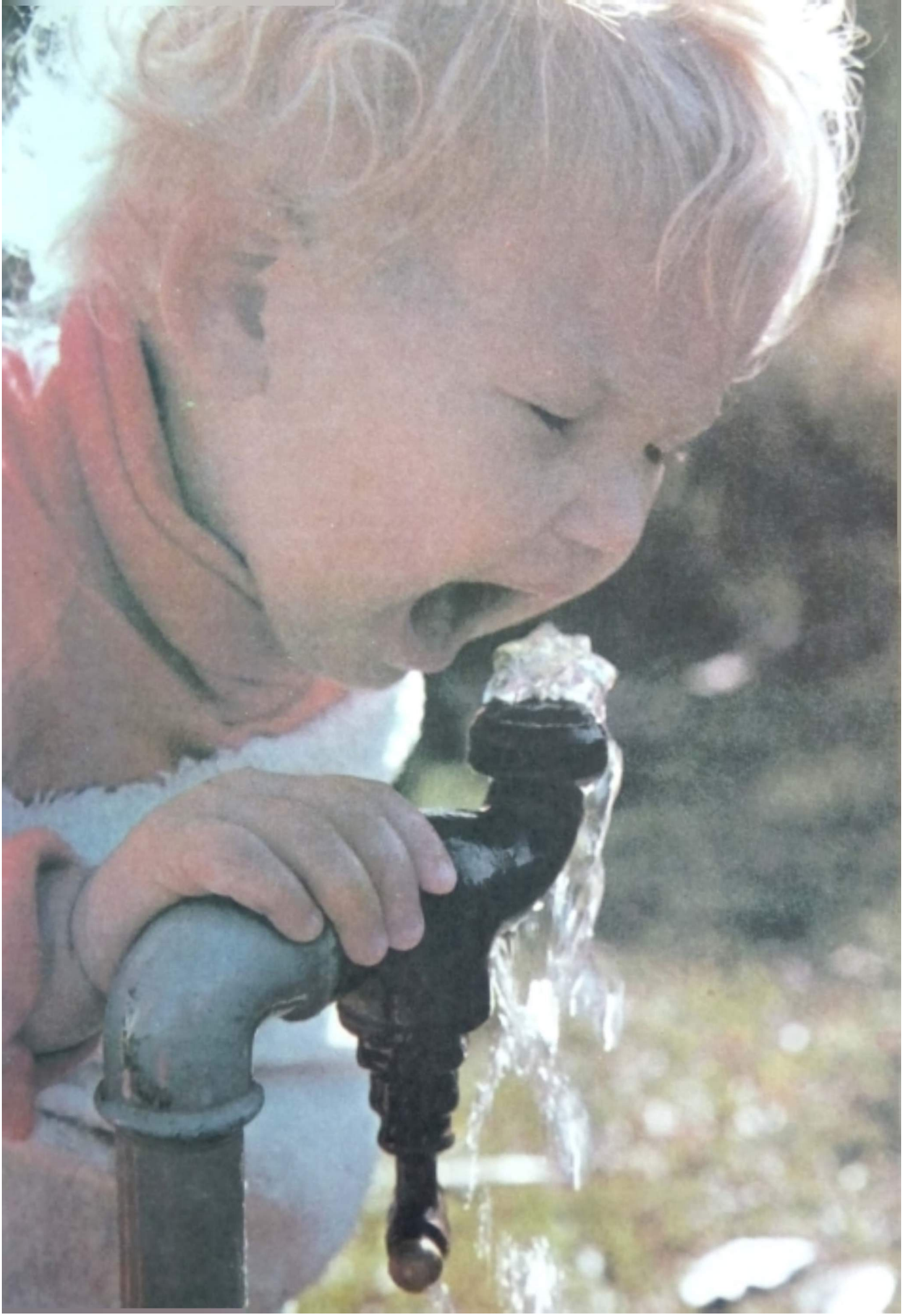
HYDROCOELE

A hydrocoele is an aggregation of fluid that appears as an enlargement in the scrotal region of the male infant.

Hydrocoeles are usually small, but they may be large, and present problems.

They can sometimes be confused with an inguinal hernia, for their location, size and appearance are quite similar.

Downloaded from Fountain of Knowledge Library



Downloaded from Fountain of Knowledge Library

A way of telling the difference between them is that a hydrocoele will sometimes "transilluminate." This means that if a small pencil torch is held close into it, it will light up like a globe, as the light beam "transilluminates" through the fluid contents. A hernia has more solid contents (bowel, often) and will not react in this manner.

It is wise to have such a swelling examined by the doctor as soon as it becomes evident. Small ones tend to disappear with time, but a large hydrocoele, especially if it is producing discomfort or irritation to the child, may be better removed surgically.

The doctor will give the appropriate advice after examining it, perhaps on a few successive occasions.

I is for . . . Immunisation, Impetigo, Infections

IMMUNISATION

Today, it is the absolute birthright of EVERY Australian baby to receive protection against the key diseases that were the big-name killers and deformers in years past.

Unfortunately, there is a growing and disturbing tendency to ignore this essential part of baby care.

EVERY BABY MUST HAVE ADEQUATE IMMUNISATION.

Below is the schedule giving minimum requirements for babies in this country.

IMPETIGO

"Impetigo" is a superficial infection of the skin caused by the "Staphylococcal" ("staph" for short) germ.

It is common in school-children, and can often be brought into the home and readily transmitted to babies.

The face and hands are the common sites for infection. But a person can reinfect other parts of his own body, as well as spreading it to other persons. This may occur directly, or via inanimate objects, such as toys, books, etc.

Impetigo starts off as small, watery, blistery sores that weep. They crust over and become brownish in colour.

Fortunately, even in these days when many resistant strains of germs are arising, these sores are still relatively sensitive to local antibiotic treatment.

Bathing the parts with a weak (very light pink) Condy's crystals solution is a good starting-point. Remove the scabs gently. Then apply an antibiotic cream or ointment. Then cover.

These products must be doctor-prescribed, for they are quite potent.

Hygiene, such as hand washing when the

Age	Protection for	Where Given	Material
2 months	Diphtheria, tetanus and whooping cough	Upper arm or buttock by injection	Triple antigen
	Poliomyelitis	By mouth	Sabin
4 months	Diphtheria, tetanus and whooping cough	As above	As above
	Poliomyelitis	As above	As above
6 months	Diphtheria, tetanus and whooping cough	As above	As above
	Poliomyelitis	As above	As above
15 months	Measles, mumps	Upper arm or buttock	Combined "m-m-vax" vaccine
18 months	Diphtheria, tetanus and whooping cough	As above	As above
	Poliomyelitis	As above	As above
At pre-school or school entry	Diphtheria and tetanus	As above	As above
	Poliomyelitis	As above	As above

Tetanus toxoid boosters are often given each five to ten years or following an external injury.

Downloaded from Fountain of Knowledge Library

sores are about (for example, at the local school) will help remove the risk of others bringing the germs into the home where baby is. It will also help keep those others free from infection. It is amazing how quickly a staph infection can race through a school.

INFECTIONS

Babies are very susceptible to infections.

During the first year of their life, they have a good deal of naturally inherited resistance to many common diseases. This comes from the mother. Antibodies circulate in the baby's system, but these do not last forever. There is evidence that breast-fed babies seem to maintain this protection for longer periods than artificially fed babies.

However, sooner or later, baby will contract some sort of infection.

Many mothers with families have acquired a degree of skill and dexterity in picking the common illnesses of childhood. They will know the serious ones from those not so serious. They will be able to decide what needs the doctor, and the ones that nature will heal with a little help.

The "first time" mother is the one with the most difficulties. She has no yardstick for comparison. Therefore she will tend to call the doctor more often than may seem necessary.

It is far better to get an expert opinion than run any risk. If in doubt, call for a doctor's advice. He can often sum up the situation on the phone, and a simple phone call can often give an answer and relieve a mother's mind.

In this modern age, help is usually no further away than your phone. It is worth remembering.

is for . . . Jaundice

JAUNDICE

Jaundice means that the skin turns from the normal healthy-looking white appearance to a yellowish hue. This can vary from an almost imperceptible shade to a deep yellow.

Also, the whites of the eyes may be adversely affected. Indeed, the whites may be the first part to become yellowish. In milder forms of jaundice, it may not extend beyond this.

Frequently the urine will become dark in colour. It often resembles the colour of tea, and the deeper the brownish colour, the more severe and serious is the condition producing the jaundice.

As the urine increases in discolouration, often the stools become lighter.

The development of jaundice in a baby should always be taken seriously. It is essential to call the doctor and follow all instructions fully.

The Rh factor was once a very serious cause of jaundice in new-born infants.

However, with the development of special serums and methods of treating the mother, this is being eliminated from the community.

If there is any chance of Rh incompatibility, the mother is given a special injection within seventy-two hours of the birth of her baby. In this manner, the chance of problems arising with subsequent pregnancy is largely reduced.

Often in the first week of life a baby will show a mild degree of jaundice. This is called "physiological jaundice of the new-born." It requires no treatment and goes spontaneously.

is for . . . Kidney Infections

KIDNEY INFECTIONS

Infections of the urinary system are common. The age group between two months and two years is the most at risk. Girls are affected much more often than boys. This is because the female urethra, the small passage that leads from the bladder where the urine is stored to the exterior, is much shorter. Infection commonly comes from the outside.

The child may have a sudden onset of fever, perhaps with shivers or a chill feeling. The temperature may rise rapidly to 40.3°C (104.5°F), but it is usually lower.

There is an intense desire to pass urine, and when this happens only a minute amount may be passed. This gives little relief, and the urge to do this again and again occurs. Irritability and vomiting may occur. There is a lack of appetite. Often there is sweating, a paleness in complexion, and in severe cases the child may become prostrate. Often the urine is cloudy, and pus may be present.

Infections of the urinary tract are very common. Indeed, although acute cases are quite common, many children and youngsters (particularly girls) have germs present witout any symptoms showing.

Downloaded from Fountain of Knowledge Library

Copious amounts of fluid given often is a good starting-point for treatment. Bed rest and a calm atmosphere are necessary. With acute cases medical advice is necessary. Medication is often given, and it may be necessary to prolong this, especially if the condition is recurrent, which it often is. Unless completely removed from the tract, these infections may produce a long-term kidney disease which can be serious.

I is for . . . Lactation, Laxatives

LACTATION

Ideally baby will be breast fed. Baby's best chances of developing normally and healthily come when this form of feeding is used.

Some mothers experience difficulties at the time of lactation. Probably the commonest one is an apparent failure of the breasts to produce sufficient milk. This problem often begins very early after baby's birth. It is essential that every effort be made promptly to ensure the milk glands are producing adequate amounts, and that the necessary stimulation for this be provided.

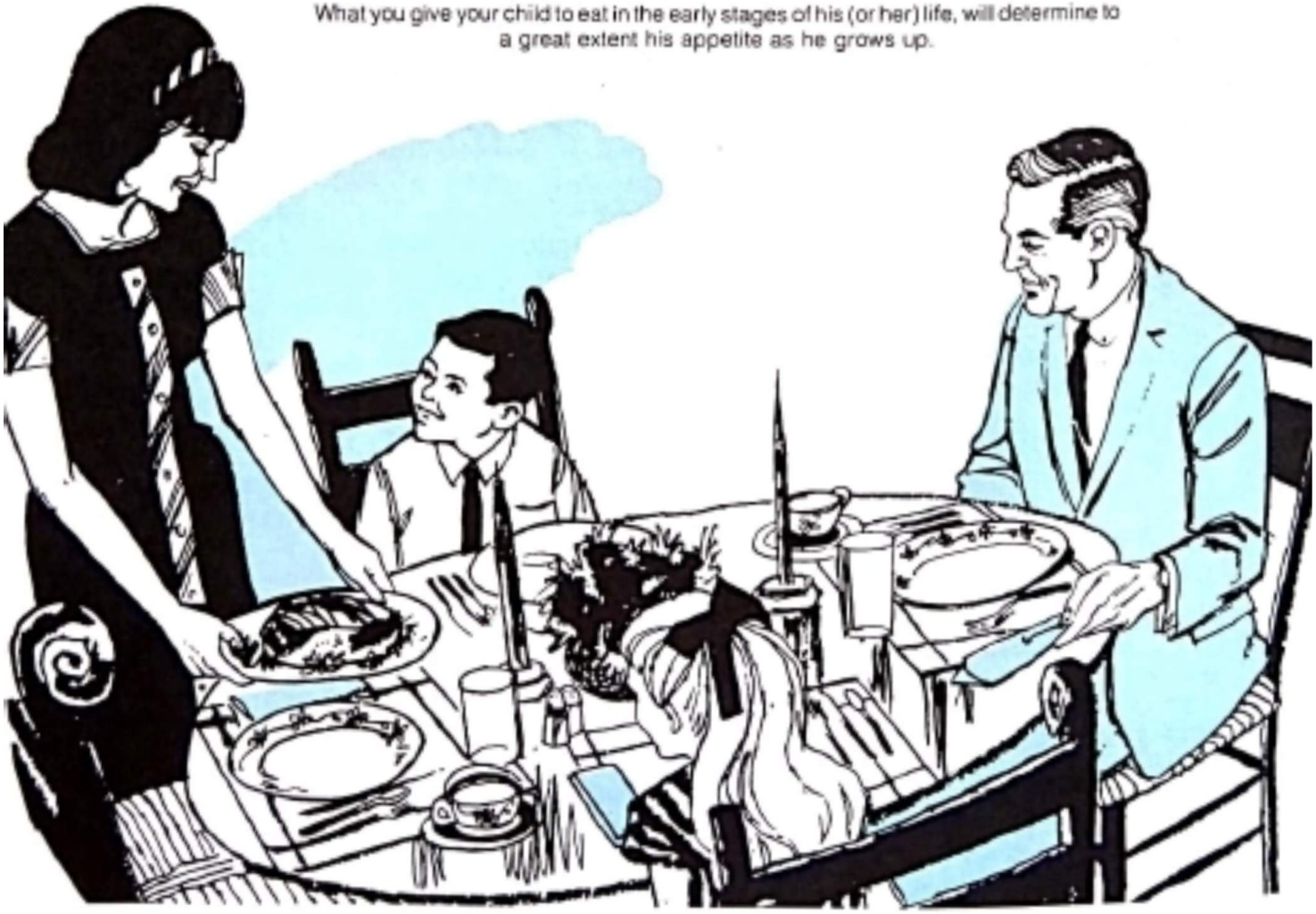
Baby may be a lethargic type, and show little interest, in the early days, in suckling. Therefore, there is little stimulus to the breasts to continue to produce milk. It is essential that the breasts be completely emptied after each feed for the stimulation to be maintained, otherwise problems are inevitable. Manually expressing each breast is advisable. Offering baby alternate breasts to begin each feed is also good.

Some baby experts have recommended that, for the first ten days, all mothers express their breasts regularly after baby feeds. This gets the milk flow off to an excellent start.

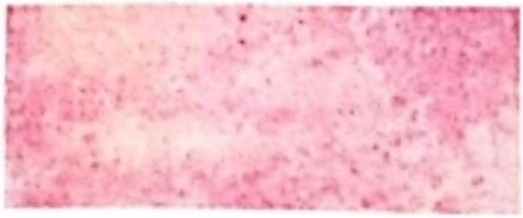
Before long, the "lethargic baby" will begin to suck more vigorously. In turn, this will promote an even greater stimulus for the glands to continue to produce milk abundantly.

However, some mothers are intrinsically poor milk producers. If there has been a history of previous difficulties, and an apparent poor supply despite all efforts, artificial feeding may be preferable.

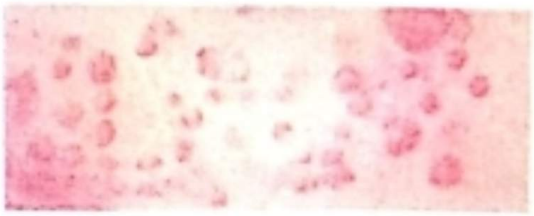
What you give your child to eat in the early stages of his (or her) life, will determine to a great extent his appetite as he grows up.



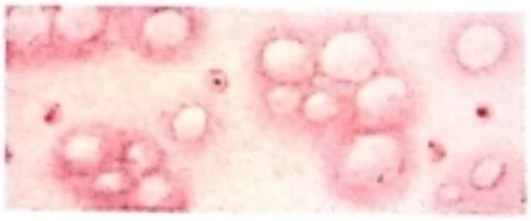
Downloaded from Fountain of Knowledge Library



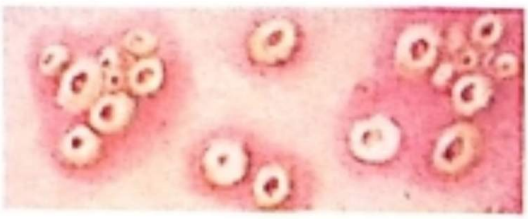
Scarlet Fever



Measles



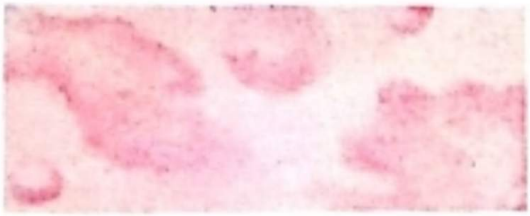
Chicken-pox



Smallpox

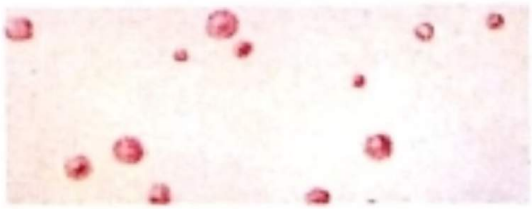
Shingles

Pemphigus



Hives

Antipyrine Rash



Typhoid Fever

Purpura

Skin Rash of Infectious and Other Diseases

Downloaded from Fountain of Knowledge Library

LAXATIVES

If constipation is present, and there is difficulty in passing hard, dry stools, laxatives may be used as a temporary measure to restore the normal bowel function.

However, the number of bowel actions a day (or week) can vary enormously. Bottle-fed babies will often go many days before having a bowel action. If these actions are soft and normal in consistency, baby is not necessarily constipated and does not need laxatives.

In hot weather, baby may lose an enormous amount of fluid. If this is not made up, either in the form of boiled water, or milk, or other fluid-containing products, he will soon become partially dehydrated, and constipation can ensue. The best way to get him back to normal is to increase his fluid intake.

Therefore, water may be the best laxative or cure for apparent constipation.

It is necessary to try to find out why bowel actions are hard and dry and infrequent before resorting to laxatives. For example, if baby has a tear at the back entrance, he tends to "hold back" (because a bowel action hurts him). So he becomes constipated, not through any real fault of his bowel system, but merely because it is more comfortable this way. Treating the tear is more important than rushing to the laxative bottle.

The doctor may prescribe a local anaesthetic ointment to be applied.

Sometimes it is desirable to help nature along. The simple method of inserting a glycerine suppository into the back passage will often produce an effective bowel action from fifteen to forty-five minutes later.

The suppository should be well covered with lanoline or petroleum jelly (and some added locally) to facilitate easy entry. Push gently, and avoid undue pressure which may produce discomfort. It is often necessary to hold the folds of the buttock together for several minutes to check the suppository slipping out. The suppository dissolves, mixes with the hardened faecal mass, and this is all expelled in the form of a fairly normal bowel action.

The suppository, of course, is used once and once only. (Some mothers believe a suppository is pushed in and out a few times, wiped, then returned to the bottle for future use! This sounds incredible, but it happens.)

In acute constipation, a simple enema may sometimes be needed. Experience is usually necessary for this, and a trained sister may have to do it. Very simple forms of enemas, commercially prepared, are available today which make this much easier to perform.

Often, adding products to the dietary intake will correct constipation problems. Adequate fluids between feeds can be curative. Increasing the sugar content of the milk may assist.

Prune juice and molasses are also advocated by some, and can be effective, as baby gets older. Adding puréed fruits to the diet of older children may be effective (such as puréed prunes and plums).

Commercial oral preparations are often used. Medical advice should be sought before any long-term use of these laxatives is started.

LENGTH

The length of baby at birth is far less variable than his weight. On average, a newborn baby measures 50 cm (20 in).

The range goes from 45 cm (18 in) to 55 cm (22 in) in a "full term" infant. Males have a slight edge on females.

The increase in length is fairly rapid in the first few months, then it gradually slows down.

In the first three months of life, baby will increase in length by about 9 cm. In the second three months, he grows another 8 to 9 cm. In the following six months, he increases his length by another 9 cm (approximately). The average rate of growth for females is marginally less.

Elaborate charts have been devised by the experts. Most babies grow at the rates indicated on the charts. However, each child is an individual, and will show variations.

is for . . . Measles, Medicine, Mothercraft, Mumps

MEASLES

Measles is a very common disease during the early years of life. Nearly every child has caught it by the age of ten years. It is extremely contagious.

Most babies receive "passive immunity" from their mother, and this lasts until the age of ten to twelve months. They are open to attack as soon as this wanes. It is carried by droplet infection among children.

Downloaded from Fountain of Knowledge Library

Initially the child seems to be developing a mild cold. The eyes are running, there is a cough and the eyes are red and look sore. The temperature may rise and he may be off his food and vomit.

Then the tell-tale rash appears. This starts behind the ears, and spreads to the face and body. The small, bright-red spots often coalesce to form huge sheets of red skin. Sometimes a day or two before the rash appears, white spots called Koplik's spots form on the inner part of the cheeks, and these are diagnostic. But they are often not seen.

Today, more and more infants are being vaccinated against ordinary measles at the age of fifteen months. This is perfectly safe and is recommended. This gives fairly high immunity for many years, probably for life.

The rash is not itchy, and does not need treatment. However, fluids are necessary. These wash away toxins from the system, and restore fluid lost by perspiring or vomiting. The child is the best guide to the type of food he desires. Soft, easily digestible food is the best. He may not feel hungry for some days.

He is very infectious during the early part of the illness. Bed rest is the best idea, but as he improves, he may get up when he feels like it.

Screen Direct Light

The idea of blacking out the room and making it akin to a dungeon is a relic from the Dark Ages. Screen out direct sunlight or bright light if this appears to worry his eyes, which are sometimes red and sore. Bathing the eyes often with weak salty water removes crusts and debris, and makes them more comfortable.

Symptoms are treated if and when they occur. Antibiotics will not cut the attack short. Coughs may respond to pholcodine elixirs. Discomfort and temperatures may be treated with paracetamol elixir (or tablets in those over six years of age).

Sometimes complications take place. Ear infections requiring antibiotics from the doctor are common. So are infected eyes, sore throats and mild chest infections. The most serious is a rare one called encephalitis. The virus penetrates to the brain and this is dangerous. Severe headaches, neck stiffness and feeling very ill are the symptoms. Medical attention is imperative.

After the attack, persistent coughing may require a chest X-ray, but the doctor will guide you if this seems necessary.

Isolation from school for several days is the rule, for the teacher is not anxious to have the germ spread around the rest of the classes.

Sometimes, a very young child or a debilitated child at special risk and who may respond adversely to the development of measles, may be given a product called "gamma globulin." This is an injection, and may impart protection after exposure in certain instances. The doctor will advise you about this if he thinks it is warranted.

MEASLES, German (Rubella)

This is quite unrelated to ordinary measles. It generally occurs in older children, and is much less infectious. It is caused by a potent virus.

Feeling off-colour for a few days is the usual way in which it starts. A few swollen glands commonly occur in the back part of the neck. The rash proper starts behind the ears, and spreads to the face and body.

The rash is quite mild, and has none of the brilliant characteristics that mark ordinary measles. The spots are very small and a faint pink. In fact, it is often more like a stippling of the skin than a definite rash. The marks may coalesce, forming a general pinkish colour to the skin. This may last a day or two. But it can frequently come and go in less than a day, and it may have gone before the doctor arrives.

Treatment is usually unnecessary, and the child recovers without any problem or complication as a rule.

The key problem with rubella is the extremely high risk it is to pregnant women in the first four months. Therefore, it is worth letting the doctor know, and it is imperative that any pregnant friends be kept away until the attack has well and truly subsided.

One attack usually gives lifetime immunity. Ideally, girls should catch rubella in childhood, for this then guarantees them safety in their reproductive years. Many catch it, but do not realise it. Vaccination is often given to school-aged girls, and this also gives relatively good protection through the reproductive period of life.

MEDICINE

As a general rule, it is not wise to administer medicines without prior advice from an expert. Today, there is an enormous range of medicines available. Many of these are powerful drugs. They have been devised for specific purposes in most cases, and are aimed at producing specific results.

It is quite wrong to push these down the throat of an infant (or child) unless there is a definite reason, and unless a specific diagnosis has been

Downloaded from Fountain of Knowledge Library

Downloaded from Fountain of Knowledge Library

made by someone competent.

Medicines should be given on a "tailor made" basis. After the baby has been examined, the doctor will issue a prescription for medication for that particular disorder. Often a certain amount is prescribed. The intent is to give the entire course, and the hope is this will correct the anomaly present. If it does not, a reappraisal is needed.

The two most common problems mothers will tend to treat themselves are elevated temperatures and coughs. Often a cool sponge will bring down an elevated temperature. If not, get medical advice.

Aspirin should never be given to babies. It can produce gross irritation of the stomach and bowel, and serious consequences have often been reported. Paracetamol elixir is the medication of choice. The dose (for age) is usually written on the label.

Cough medicines may be given when a nasty cough is present. Many products are available. The pholcodine elixirs are suitable. Doses are usually on the label. For anything else, get medical opinion first.

MOTHERCRAFT

This subject entails a general knowledge of the basis of baby care.

Experienced mothers know what to do. First-time mothers are not so well informed. They are feeling their way, and have no yardstick for comparison as their more senior counterparts have.

In most hospitals, a certain amount of experience can be gained in the days following the confinement. The staff is usually happy to show the new mother how to go about the basics of caring for baby.

Baby health centres provide excellent service for mothers with their new babies. The trained sisters will readily give able assistance, advice and encouragement. They will also provide booklets and general information, will weigh the baby regularly and discuss feeding or other problems. The centres are worth attending.

MUMPS

This is an infection of the glands that produce the saliva. Most commonly the big parotid gland located in front of each ear is infected. Both sides usually swell.

The jaw becomes painful, and opening the mouth and eating and talking may become uncomfortable. The mouth may feel dry, due to a reduced amount of saliva being formed.

Downloaded from Fountain of Knowledge Library

There may be an elevated temperature, and the skin may feel tingly and sensitive. Sometimes the body may feel shivery too.

It usually takes several weeks for the virus to produce symptoms. It is infectious, and it commonly occurs in children of primary school age.

Occasionally the virus travels to the testes in boys or the ovaries in girls (mainly after the age of puberty). It may produce swelling and discomfort in these regions, and on rare occasions may produce sterility, although this is uncommon.

Bed for a few days is recommended. Fluid to replace that lost from sweating is desirable. It also helps rid the system of unwanted toxins. Simple analgesics like paracetamol elixir (for those six years and under) or paracetamol tablets for those older, will reduce fevers and alleviate aches and pains. Nourishing drinks, such as milk drinks with egg, and soft foods are advised.

A combined mumps-measles vaccine is now available. It is recommended for babies at the age of fifteen months.

n is for . . . Napkins, Nappy Rash

NAPKINS

Over the years, napkins have undergone all sorts of changes in regard to the way they are applied. It doesn't matter how they are placed, so long as they do the job for which they are intended, stay in position and are readily changed without too much fuss and bother.

The napkin itself can produce problems for baby and mother. Care with laundering is advisable. The use of synthetic detergents in recent times has made this less of a hazard than previously, when soaps remaining in the material could aggravate and irritate the skin and predispose to rashes and irritations.

It is worth giving nappies a good sunning, and this method of drying is preferable to artificial drying methods. The sun is the best-known killer of germs yet devised (and it is free). If the washing water is hard, the use of water softeners is advocated.

In recent years a large number of worthwhile nappy liners have appeared. Some of these are aimed at keeping urine from the skin. By allowing fluid to pass "one way only," it soaks into the nappy, but the skin is kept relatively dry. These liners are excellent.

Other nappy liners, often using wood pulp as a base, are aimed at rapidly soaking up the urine effectively. These are sometimes worn inside the napkin, so protecting the napkin and giving it a longer period of usefulness.

The value of these liners must be offset against their cost; and also the problem of how to dispose of them. But they certainly have a place in the modern home.

Disposable napkins have also appeared in recent times.

NAPPY RASH

Baby's skin is very tender and sensitive. For this reason it is wise to avoid anything that will produce irritation.

Nappies are essential, but they may produce problems. They prevent adequate aeration of the buttocks and areas between the legs. These parts can become overheated, perspire excessively, rub, become chafed, and in due course, the skin complaint commonly called nappy rash appears.

This is usually a reddening of the skin areas under the nappies. It can proceed to a fiery red

Baby's skin is super-sensitive. Take care in your choice of soaps and nappy detergents.

Downloaded from Fountain of Knowledge Library

rash; pimples and blisters may form; infection may get into these, and produce raw areas which may be irritating and painful.

Wet nappies left in position can rapidly aggravate the problem, or they can initiate it. Urine decomposes rapidly, producing ammonia which is a very harsh irritant. Bowel actions left can also irritate the tender baby skin and aggravate irritation.

Care in changing nappies as soon as possible after they are wet or soiled will greatly assist in preventing the onset of trouble.

Letting baby have a good kick about with no nappy on at all is an excellent idea. Left in the early morning sunshine for a while, he will respond well to his new-found freedom. (Be careful not to overdo the sunning, or let the hot sun burn him.)

Cleansing any rash with cotton-wool and liquid paraffin is very soothing. Then apply zinc cream (best with a little tar in it—there are many commercial products available). Rub in gently.

is for . . . Overfeeding

OVERFEEDING

There is nothing so fine as a well-fed, contented baby. But in recent years, more and more attention is being focused on the fact that many babies are overfed.

The experts seem quite adamant that giving baby too much can produce problems which are long-term.

Overweight babies produce overweight infants. In turn, overweight children and adolescents develop. Finally, the unhappy, unhealthy, overweight adult is produced. The inherent dangers of this are only too well known, to say nothing of the aesthetic problems involved.

The *British Medical Journal* recently stated that "20 per cent of children who were overweight in the second six months of life are still obese five years later." Also, "80 per cent of obese school-children remain obese in adult life."

Undiluted cow's milk contains very high levels of minerals and protein, and it is necessary for fairly large amounts of fluid to be taken to cope with this. Many mothers prepare artificial feeds in too strong a form, either using tightly packed scoops or adding additional scoops in the belief they are giving baby better nutrition.

In fact, they are producing problems for baby, which may have long-lasting repercussions. It is essential to follow carefully the advised dilutions, and "don't over-do."

The too-early introduction of solids is also blamed for producing overweight babies.

Moderation at all times is a good rule to follow.

is for . . . Phenylketonuria, Poliomyelitis, Prickly Heat Rash, Prune Juice

PHENYLKETONURIA (PKU)

This is a disease inherited by a small number of babies. Unless it is treated from an early age, it may produce severe mental retardation in later years.

In most Western lands, newborn babies are now tested routinely for PKU at birth. This is carried out on a drop of blood, usually on the sixth day of life.

Previously, a urine test was done, but this has now largely been superseded by the more accurate blood check.

Immediately the disorder is diagnosed, the baby is placed on a special diet which is low in a certain chemical which is the known trouble-maker.

This must be continued for several years. It does not now seem necessary to continue the dietetic restrictions for life as was originally believed.

Subsequent tests every few years give an indication of the need to continue therapy.

The condition is inherited from parents. Although they may not have the disease, they carry a "recessive gene," and sometimes this will produce it in their offspring.

POLIOMYELITIS (Polio)

Fortunately since the advent of vaccination against polio, this dread disease has largely stopped being the major killer and producer of deformities that it once was. In fact, many doctors have seldom, if ever, seen a true case of polio.

Parents must not neglect to have their children immunised (see "Immunisation"). By constantly keeping the level of immunity high in the community, the disease will be kept to a

Downloaded from Fountain of Knowledge Library

minimum. But if negligence takes over, there could be a major return.

Although in Western lands polio has reduced, it is still rife in many of the developing countries. So, if travel is being contemplated, it is essential that further attention be given to vaccination, or revaccination.

Those catching polio following immunisation (and there may be a few) have a very reduced form. It becomes a mild illness resembling a cold, and may go undiagnosed.

Incubation is up to three weeks.

PRICKLY HEAT RASH

This is very common with babies, and is more prevalent in hot summer months. It is also commoner in humid weather when moisture in the atmosphere becomes an added irritant.

Heat rash can occur anywhere. It is common on the face, and in the folds of the neck. It can encompass any part of the neck, and may spread to the trunk or limbs.

It occurs as a fine sheet of pimples. These are very irritable and baby may tend to rub at them. But this does not give any relief—it tends only to aggravate the situation.

Often the condition is made worse by certain fabrics rubbing. Wool, or harsh materials, will irritate the affected areas. Some soaps or harsh washing products (which may still remain in materials coming into contact with the skin) can aggravate.

Preventing overheating, especially in hot weather, is important, particularly in babies that are prone to this skin irritation.

The use of loose-fitting cotton garments is advisable. Avoid irritating clothing. (A mother will soon know the type of material which seems to aggravate baby most.)

Plastic pants can prevent adequate aeration, and are best not used during hot weather.

Avoiding the over-use of soaps (which are often harsh in nature and irritating to sensitive skins) is advisable. Applying any of the simple soothing creams and lotions will give a certain amount of relief from irritation or itch. Calamine creams and zinc preparations in various forms can help. But basically, the condition will be cured if causes are avoided.

PRUNE JUICE

The idea that prunes (and prune juice) are the "ideal laxative" has been around for many decades. Indeed, prunes do have a beneficial effect on the bowel of the baby and infant.

Prunes have the advantage of being mild, natural food, readily available, easily prepared, and usually effective. Plums, which are in the same family, are sometimes used with equally beneficial effect.

When baby's bowel actions are hard and dry (irrespective of how frequent they are), he may benefit from the use of prunes.

A common "dose" of prune juice is 15 ml (one half ounce) a day. This will frequently be quite sufficient to produce a nice, easy, soft bowel action each day. For older infants, pureed (sieved) stewed prunes can be used instead of, or in conjunction with juice. The amount needed will vary from infant to infant, and the mother will soon discover from simple experimentation the amount producing the ideal results.

If attention is given to increasing simultaneously baby's daily fluid intake, an even better result will often occur. Adequate water is essential for normal "regularity"—a fact overlooked by many mothers. This is especially true in hot weather.

is for . . . Questions

QUESTIONS

Is my baby normal? . . . When will he start walking? . . . How long before his teeth start showing (none yet, and he's four months old) . . . He isn't talking yet . . . Shouldn't he be picking things up and showing more interest (like the neighbour's baby)? . . . and so on.

Every mother believes her child should at least be above the national normal standard. However, questions on development, and when this or that should take place, exercise all parents' minds sooner or later. This is invariably aggravated by checking with others of similar age, or from questions from well-meaning relatives (usually grandparents).

The average baby will develop normally and naturally, irrespective of what you do to try to hasten this along. After all, baby humans are just another facet of nature. Cows and horses, dogs and cats manage to do quite well and generally develop in a normal healthy way without the need of textbooks and specialists or oral advice. Babies (with two legs) are not much different.

Do not expect too much too soon. There are enormous variables. One child will start to teethe

Downloaded from Fountain of Knowledge Library

early. Another will start months later. But the end-point is identical. Maybe the late teether will have better teeth in the long run. Trying to force baby along the channels can breed problems, both for you and him. Take it gently. If there are any obvious problems looming, consult your doctor. If there is any major query in his mind, he will get the expert opinion of a paediatrician.

is for . . . Respiratory Problems, Ringworm, Rusks

RESPIRATORY PROBLEMS

This huge group of problems forms one of the most common areas into which most babies will come sooner or later. It is very easy to pick up an infection. This can range from a simple "snuffly nose," to a cold, to a throat-tonsillar infection, to bronchitis.

Basically, they are all progressions of the same disorder.

Germs can be introduced into baby's airway system readily, especially in winter months. The germs are attached to microscopic airborne droplets. When inhaled, they tend to set up a focus of infection which may rapidly extend, so producing symptoms in its wake.

The symptoms will vary, depending on the area affected. But, severe general symptoms can occur. An elevated temperature is usual. Babies will run a fever at the slightest pretext. (Conversely, they will recover just as rapidly in many cases.)

Coughing is a common symptom. Pain in any of the affected parts may take place. Baby may indicate this in various ways, for instance, pulling an ear if it is sore and inflamed; holding the head and crying if this is involved and painful.

Simple measures can often assist simple infections and inflammations. Paracetamol elixir is good for bringing down elevated temperatures. Doses are usually marked on the bottle and related to age. Avoid aspirin preparations for children, for these are notorious for producing gastric upsets.

Pholcodine products can often assist in relieving coughs. This is a safe and effective product. (Consult bottle label for dose.) But many other products are commercially available, and many are suitable.

Any fever or severe cough persisting for longer than a day should have proper medical attention from the doctor.

RINGWORM

This is a common condition seen in little children. It is an infection with a "fungus" (a particular variety of germ). The association of children with animals (which frequently transport the infection) and their subsequent association with baby can affect even the youngest. It is very contagious.

The infection can occur on the scalp or body or limbs. In the scalp region it may produce a loss of hair (in fact it is the commonest cause of patchy hair loss in children.)

On the skin elsewhere, it presents as a "ring" ("ringworm"). This may be inflamed, or be scaly, with a spreading margin.

Usually there is little if any irritation. It just appears, and starts growing.

These lesions usually respond well to treatment. In recent times, a product readily available called Tolnaftate (in liquid form) can quickly get rid of it. (Various commercial forms are available.) But the older products, such as Whitfield's Ointment, and Castellani's Paint (a wild magenta colour, hated by mothers if it gets onto clothing or bedding) is often effective.

It is worth while treating anyone else in the family who may have the infection, for it will inevitably be passed on to the other members sooner or later. In the scalp, oral griseofulvins can produce dramatic results. This comes in tablet form, and proper medical supervision and prescribing with this strong product is essential.

Sometimes, one single lesion occurs. After this has been treated with a local application, it is best covered with an adhesive strip to check its spread.

RUSKS

These have been around for a long, long time, and many mothers still find them very useful. They are a very hard, compressed biscuit, and baby loves biting and chewing on them when he is getting his teeth.

Of course, the inevitable result is the mess they make! Baby gets partially dissolved rusk all over his lips, face, hands, bedclothes and his own wearing apparel. But he is invariably happy and contented when munching and sucking away.

Many believe these are more hygienic than teething rings, or letting baby suck other toys and hard objects which he will inevitably want to do

Downloaded from Fountain of Knowledge Library

when his teeth are starting to come through.

Indeed, one single rusk can last baby for many hours. This is good, and many mothers are given a chance to get away and do some much needed housework.

There is a risk that pieces of rusk can break off, and there is a possibility, admittedly not high, of this becoming suddenly inhaled into his windpipe. Cases are on record, but one has to be very unlucky. But it is worth keeping in mind. If baby is in the other room, chewing on his rusk, pop in from time to time and check to see that he is all right.

The risk of any sudden disaster occurring is fairly small.

S is for . . .

School Refusal,
Smoking Mothers,
Solid Foods,
Spoiling,
Sun Baths

SCHOOL REFUSAL

Some children exhibit a persistent refusal to attend school. It may commence as a mild reluctance, but progresses into a total refusal. It may remain despite persuasion, threat or punishment.

This abnormal behaviour may be associated with an obvious fear, anxiety or even panic that takes hold when the time to go to school arrives.

Some cannot even force themselves to leave home to make their way to school. Others will go part of the way, then turn back and come home. Others may reach school, then suddenly rush out of the building, run home in a state of abject misery and near panic. Many of these children insist that they want to go, but when it comes to the actual event, they fail.

Some cases present with this clear-cut picture. But more often it is disguised in some form of somatic overlay. The child may complain of any one of innumerable symptoms. Loss of appetite, limb pains, nausea and vomiting, feeling faint, are all well-known symptoms.

They are present before school. But they invariably disappear soon after the decision to remain home has been made. They are generally surprisingly lacking at week-ends.

This may occur acutely in a younger child, and is associated with a fear of leaving the parent. But it can take place in older children also, and may come on more insidiously.

Efforts to reduce family or school tensions and anxieties must be made. Taking a firm stand is essential. Psychological counselling may be necessary, and a sedative may be prescribed.

SMOKING MOTHERS

Most mothers-to-be should be well aware of the potential hazards of smoking during pregnancy. The medical magazines have been documenting the possible adverse results for many years now. Any pregnant woman is strongly advised to stop smoking completely. If this is not possible, a drastic reduction is recommended. This is for her own welfare, and also that of her baby.

Smoking mothers miscarry far more often. They have more "still-births," and babies that die soon after birth. Their babies are often lighter than would be normally expected, which means they are destined for greater risks in the early months. Premature births are more frequent also, with the attendant risks of this.

It has now been fairly well documented that babies born to smoking mothers tend to perform more poorly at school on the mental level. Surveys carried out on children in the six- to ten-year segment indicate this, and trials in the United Kindgdom are emphatic in their recommendation, again, that mothers refrain from smoking.

However, even more recent evidence incriminates smoking as a potential hazard to the new baby. If baby is subject to frequent smoke exposure (e.g., his mother smoking in the house), the chances of contracting respiratory and other illnesses increase considerably.

In fact, baby becomes a "passive smoker," and has some of the inherent problems that the person who is directly smoking has.

Therefore, mothers can save themselves a lot of hard work (for having a sick baby involves work plus worry) by keeping their smoking to an absolute minimum. It pays off well . . . and think of all the money you save!

SOLID FOODS

At present there is a major controversy being waged by the experts as to the best time to introduce solid foods into baby's diet. Some claim that milk provides the essential ingredients for adequate nutrition for the first three months. Others cling to the older ideas that solids may be introduced in a fairly liquid form during the first month after birth.

The current view is to be cautious. There is no need to be over-zealous in feeding a mass of

Downloaded from Fountain of Knowledge Library

Involve your child in your activities, both indoors and out of doors.

solids to a baby too early in life.

However, little by little, they can be introduced. It is a good idea to vary the nature of solids given. Pre-cooked baby cereals are often a simple and convenient way to begin. But egg (possibly in the form of custard to start with, then separately in the three- to five-month period), stewed fruit and mashed vegetables are also suitable.

There has been much made in recent times of "educational feeding." This idea is to acquaint baby with some of the huge range of varying tastes that he will come into contact with as he gets older. This can conveniently be started in the three- to six-month period.

SPOILING

Nowhere is the art of tender loving care more intimate than between a mother and her baby. The mother, out of sheer natural instinct, devotes all her time and energy to caring for her children.

There is an enormous bond of affection inherent in the breast-feeding routine, and a tremendous tie grows up between mother and baby. This is natural and desirable. In fact, it is one of the most beautiful facets of living, as every mother knows so well. It is compensation for the hours of hard work which the baby entails.

Especially with first babies, the number of hours a mother may devote to the baby can be enormous. She will feed him, bath him, play with him for hours. Nothing gives a mother more satisfaction than seeing a happy look of recognition on her baby's face when she comes to him.

But a note of caution: overdoing the loving routine, and bending to every whim of baby can

Downloaded from Fountain of Knowledge Library

have repercussions.

Spoiling baby is so simple, so easy, especially when he is the one and only. Baby learns very quickly how to attract attention, how to get what he wants. A mother who gives in to his every whim and whimper is heading for troubled times. Also, if and when Baby Number Two puts in appearance, Number One must have less time spent on him, and this is likely to produce a problem.

SUNBATHS

Allowing baby to have a good kick around in the sun is a good idea. Often this is best during early mid-morning.

Baby will love the freedom, devoid of constricting nappies and clothing. He will gurgle, toss and turn and wriggle in the most enjoyable fashion.

Sun baths help to harden sensitive skin areas, particularly the buttocks and "perineal" areas (between the legs). This will help baby's resistance to nappy rash and other skin problems.

Sunshine is the world's best germ killer. It will help him to stave off impending infections in many cases. It also helps the body produce vitamin D, necessary for bone formation.

It is essential to take care. Hot sunshine can burn tender skin very easily. It is important that baby should not be overexposed, especially in the early stages of his sun-kicks. A few minutes each day is all that is needed. This may be gradually increased as he shows tolerance.

An added note of caution: you must protect baby's eyes from direct sunlight. It is distressing to see mothers pushing strollers with their babies in the full glare of the oncoming sunlight. Eyes are very sensitive; permanent damage is possible.

is for . . .

Teats on Bottles,
Teething,
Thrush,
Thumb Sucking,
Toilet Training,
Tongue Tie,
Tonsillitis,
Toys,
Travelling

TEATS ON BOTTLES

Hygiene at all times is essential. The teat should be always sterilised before use. An enormous number of germs can lodge on a single teat; in this way, disease can be readily and rapidly transmitted to baby.

This is even more likely during summer. At all costs, the teat, both before and during the feed, must be adequately protected from flies.

Flies settling on baby's bottle teat even for a few seconds can allow enough gastric (or other) germs to be left behind to produce illness.

The hole in the teat is very important. If the hole is too big, milk will spray out at a far greater rate than baby is able to cope with. If this is the case (and you should always test the rate of flow), get a new teat. A gentle, constant drip is all that is required.

A teat with too small a hole is also a problem. It means baby has to suck too hard to get his meal. He may tire quickly, lose interest, and perhaps have inadequate food intake. In an hour or so, he will be crying for more food.

Violently sucking at a small-holed teat can also allow him to swallow much air, which can produce discomfort.

TEETHING

Teething time can often be a problem time, not only for baby, but for the parents.

As baby cuts his teeth, he often becomes unhappy and irritable. He often runs a fever as each new tooth endeavours to cut its way through the gum surface.

Sometimes, the top of the pearly white tooth emerges with little sign of anything more happening. At other times, a bluish-black area may occur over the top of the tooth about to erupt. This may be present for some time.

Teething usually commences about the age of six months. It then continues at intermittent intervals up to the age of two years.

There are great variations, and parents frequently become worried that baby is "slow" in teething. There is very little to fear. Invariably, they arrive, all intact, and able to do their appointed duty.

The central incisors on the lower side usually appear first, between five and eight months. The upper central incisors come next, together with the lower lateral incisors. The second molars at the back appear at twenty to thirty months.

Many illnesses may take place during the teething period. Diarrhoea, skin rashes and eruptions, recurring ear infections, and respiratory infections are quite common. These should all be treated. It is wrong to neglect them in the belief they are "due to teething."

THRUSH

Thrush is the common name given to an infection of the oral cavity, and it is common in

Downloaded from Fountain of Knowledge Library

babies. It is seen usually on the inner sides of cheeks. Creamy-white areas develop, and these may gradually increase in size. There seems little discomfort to the baby, and certainly the condition does not appear to be painful.

If the doctor removes these creamy white areas, the tissue underneath looks red and raw, and unless it is done very gently, it may bleed.

However, there is no need to try to remove the areas of thrush.

Thrush is caused by a fungus infection called "Candida albicans."

Fortunately, treatment has come a long way in the past few years. The best method is the use of oral drops of a chemical called natamycin 1 per cent. Four drops are placed under the tongue after each feed. The product (which is commercially available under its own trade name) comes in a plastic container (with dropper) in one per cent strength. It is available on National Health service on a doctor's prescription. Very soon this will destroy the fungus, and the whitish areas will gradually disappear without any further effort.

In times past, gentian violet was commonly applied. This produced an unsightly appearance, and indelibly stained clothing and bedding. However, it was a very effective form of therapy. But modern medicine, fortunately (and to gladden the hearts of mothers) has come up with this alternative product.

THUMB SUCKING

Thumb sucking is a universal baby pastime. It is a projection of breast-feeding. To baby, it may spell comfort and solace. It may represent a sense of security, particularly when outside influences are having an adverse effect.

Thumb sucking tends to increase up to the age of two years. It may be the thumb, or fingers, or

Downloaded from Fountain of Knowledge Library

the whole hand. Basically, it is the same physiological process.

After age two, the habit tends to wane, as baby turns to other facets of interest.

Sucking the thumb after this age should therefore be discouraged. Many babies suck their thumbs when they become tired, and proceed with this until they drift into sleep. It is possible that continual sucking, when asleep, can build up an enormous pressure inside the oral cavity.

The thumb can press against the teeth. Some claim this may be responsible in helping to produce "buck" teeth.

In any event, the constant thumb sucker is best checked after he falls asleep. The mother may gently remove the hand from the face and slip it unobtrusively by his side. This seldom produces any adverse result; baby usually sleeps happily through the simple action.

If this is persevered with in those who persistently suck, gradually the habit tends to wane until it is overcome entirely.

In those that show a chronic and intense desire to persist with the habit, the doctor should seek some underlying problem.

TOILET TRAINING

Baby's toilet training is an emotive subject. It is enshrouded with social standing, status, and pride. As one expert on baby care recently wrote: "To some mothers their baby's toilet control ability represents a desirable status symbol, and these mothers will wish to start training early."

However, it is pointless trying to expect the impossible. This is only one aspect of all infant training. It is foolish to expect remarkable achievements when one will readily accept the fact it will take months or years for other facets of baby's upbringing to develop.

The majority of infants do not achieve the ability to control their bowels and bladders until well into the second year. In many cases, it is much nearer the third year.

Mothers will hotly dispute this. However, for those claiming early success in their "potty" experiments, the chances are more likely to be that the mother has been trained rather than baby.

Baby's system has several well defined reflexes. One of these is the bowel reflex. Soon after food enters the stomach, many babies have the desire to have a bowel action. If the mother has become accustomed to giving baby the potty at this time, she will mistakenly believe she has "trained" him.

Be contented to take time, have patience, and do not expect miracles in the training programme. Gentle encouragement will give great rewards; early premature expectations can only produce hazards later.

TONGUE TIE

All sorts of symptoms are blamed on to innocuous "tongue tie." This very seldom produces problems, but if it does, the solution is simple.

Sometimes the "frenum," the thin membrane that runs along the midline of the tongue on the underside, may be short and thick. It may extend almost to the tip of the tongue. This may give difficulty when baby is sucking, and occasionally can interfere with normal feeding.

As he becomes older, it may produce difficulties in forming words when he is learning to speak. Sometimes it may prevent the normal movement of the tongue. This may be important in preventing his tongue from the customary movement, which permits the tongue to cleanse the inner side of the teeth.

As he becomes older, the frenum usually lengthens, and the problem is frequently a self-solving one.

If symptoms are present, and difficulties are being encountered, it is a simple job for the doctor to cut the frenum gently, so permitting greater activity and freedom of the tongue.

Care is needed to do this. Large vessels are present in the frenum further back. It is essential that these be avoided, or bleeding may take place.

TONSILLITIS

Infection of the throat and tonsils is very common during childhood.

The tonsils are the large glands, one on either side that sit in the back part of the throat. They are very susceptible to infection by bacterial organisms. They are there principally to trap germs from entering the system. But so often they seem to lose their correct function, and instead become infected with the very germs they ensnare.

Often the throat is sore; swallowing becomes difficult, and there is an elevated temperature. The glands under the jaw often swell and become painful also.

Looking down the throat, you can see the enlarged tonsils protruding from either side. In severe cases they are covered with a yellowish

Downloaded from Fountain of Knowledge Library

cheesy-looking material which is pus from the infection.

Sometimes the throat may also be red and inflamed, with little swollen areas of "lymphoid" tissue present and inflamed. This may occur with or without tonsillar infection.

The majority of cases settle down promptly with treatment. This is usually in the form of antibiotics given by the doctor. Penicillin is often still effective, but other antibiotics may be needed.

Coughing, generally a normal bodily function, is sometimes a symptom of disease.

Paracetamol elixir (in infants) will help relieve the elevated temperature, the pain, together with reducing the chill feeling and aches and pains that abound in many parts of the body. The joints, large muscle areas of the back, upper arms, and thighs may be very tender. Medication every few hours will relieve this.

Bed Rest

Rest in bed for a few days while the temperature is high is a good idea. Plenty of fluids (water, lemonade, fruit juices, and other water-based drinks, hot or cold) are advisable. Hot drinks often reduce the local discomfort in the throat.

Fluids tend to replace that lost through perspiration. Adequate amounts also increase urination, and this is an excellent way to eliminate impurities and the by-products of the infection from the system. Time of treatment may be anywhere from three days to a week or even longer. Pus-infected tonsils may take more time to settle.

An occasional attack of tonsillitis in an otherwise healthy child is not a reason to have the tonsils removed.

Those days have long since ended. It was a very common childhood surgical operation, but now very few are being performed.

The recognised indication for T and A's (as the operation is commonly called by doctors) is severe, recurring bouts of acute tonsillitis. This means three to four attacks or more a year.

With increasing age, most children develop resistance to these attacks, and overcome them with lesser degrees of debility. So do not badger the doctor to have the operation done.

Many doctors believe the removal of the tonsils may leave an open wound through which other more serious germs could gain access to the system. (In pre-polio vaccination days, it was thought the polio germ often entered the body via such wounds.)

TOYS

What baby doesn't have a room half filled with toys? It seems incumbent upon every neighbour, relation, friend to ply the new baby (and growing infant) with toys.

It is surprising how often baby (and infant) will spurn all the expensive products for an old tattered doll, a bunny, or a bit of rag.

In selecting toys, care is essential. Of special risk are toys with small pieces of plastic that can be removed. Buttons (any type, especially small ones), bits of hard plastic, or anything that is hard and small is potentially dangerous. Very large numbers of children pull these off, and proceed to suck them or poke them into their nostrils and ears.

Inhaling a foreign body can be extremely dangerous. It seldom produces death, but if it lodges in a vital passageway, it necessitates emergency treatment and an operation.

So, beware when next buying toys. If well-meaning friends give toys, just check before unleashing them on to the child. Educational toys are the best idea. These can teach the growing infant something, and should be preferred wherever possible.

TRAVELLING

Plenty of circumstances will occur where baby has to travel with the parents. This can pose a variety of problems and it is worth considering them carefully before the envisaged trip.

The key factor is the altered routine which

Downloaded from Fountain of Knowledge Library

Downloaded from Fountain of Knowledge Library

baby always faces. Baby becomes accustomed to his normal schedule, and finds this very suitable and satisfying. Any sudden variation from this is a jolt to his system. He does not take to it very kindly in many instances. So, be well warned.

It is almost impossible to take a trip (wherever or whatever kind is planned) which can be tailormade to baby's set routine.

Do not be too upset if baby is unhappy, for much of the time. He will get out of his regular eating habits; his sleep pattern will most likely be altered. His environment for sleep will be different (every day perhaps). So irritability, crying, showing signs of discontent, possibly going off his food, being "bad tempered," bowel irregularity, and vomiting are some of the possibilities.

An effort should be made to adhere as much as possible to baby's usual routine. This will help.

Feeding facilities must be well thought out; feeding supplies, bathing facilities, etc., must all be carefully planned.

Another problem is the napkin one. Disposable nappies are now widely used. But there are problems associated with disposing of the soiled products. Give this some thought, for you can't throw them out of the car window.

U is for . . . Umbilical Problems

UMBILICAL PROBLEMS

Before birth baby is fed through the umbilical cord. This is sealed off at birth, leaving a scar called the navel.

Some fairly simple problems may occur. Most of these settle down without too much difficulty. But it is worth knowing about them.

Occasionally infection can take place in the early days, either just before or just after the cord comes off. This needs prompt treatment, for rare cases develop into serious infections. Any discharge from the area should be treated seriously and medical guidance sought.

Sometimes "granuloma" develops. This is a meaty-looking growth of tissue. It is not serious, but fails to heal. The doctor will apply silver nitrate stick to it for a few days.

Perhaps the most common problem is the umbilical hernia. This is produced because the underlying muscles, through which the cord travelled, fail to close over the hole. The internal abdominal contents tend to protrude through this artificial orifice. A lump develops at the navel.

These hernias occur in one infant in six. Many small hernias heal of their own accord by the age of two. Even larger ones tend to heal without any treatment, and most have gone entirely by the age of six.

Some parents become very worried by the appearance of these lumps. They can become unattractive, and swell markedly, if baby often cries loudly. However, complications are rare.

V is for . . . Vitamin Needs Vomiting

VITAMIN NEEDS

Vitamins are certainly an important factor in life. Fortunately, the average Australian diet, both for baby and adult, is adequate in most cases to meet daily vitamin needs.

However, some babies do have vitamin deficiencies. The most likely to be encountered are those due to a lack of vitamin C (ascorbic acid) or vitamin D.

Vitamin C is present in breast milk. If baby is breast fed, and is taking a reasonable daily intake, his vitamin C needs will be adequately catered for.

Cow's milk is devoid of this vitamin. A supplement is essential. This is most simply given in the form of orange juice, which is very rich in vitamin C. One orange contains about 60 mg. It is essential that the juice, when squeezed, be not boiled, for this could destroy the entire vitamin C component. Give it to baby freshly squeezed. This can be done between feeds. It can serve a twofold purpose—adding to his fluid intake, and providing the essential vitamin.

Scurvy is the disease produced by a lack of vitamin C.

Rickets, due to a lack of vitamin D, is uncommon in Australia and New Zealand. Sunshine assists the vitamin to be produced in the body. However, occasionally cases of premature babies with rickets have been reported.

Taking a vitamin supplement is practically standard practice in Australia and New Zealand for babies. Doses are usually marked on the label.

VOMITING

Just about every baby will vomit. Many babies vomit after a feed. This is quite normal in most

Downloaded from Fountain of Knowledge Library

Downloaded from Fountain of Knowledge Library

instances, and is called "possetting." Often, air is swallowed with the feed.

This eventually comes up, and a certain amount of fluid comes away also. This is different in consistency to the normal milk that was ingested, for it has been acted on by the stomach secretions and has clotted.

A baby lying on his stomach is less likely to vomit (with wind) than one lying on his back.

It is always wise to burp baby adequately after a feed. Holding him over the shoulder allows air to rise and to escape through the valve promptly.

Patting does little to help the burp, but may soothe the child.

No case of vomiting should be taken lightly. If it comes on suddenly for no apparent reason, investigation is often needed.

Almost any illness may produce vomiting in a small child. Some cases are serious, and persisting. "Pyloric stenosis" (where the tube leading from the stomach to the bowel is narrowed) is an important disorder needing attention. Vomiting for this disorder may commence soon after the fourteenth day. It may become more and more forceful and eventually projectile, which is usually a typical symptom. Urgent medical attention is necessary. Food simply refuses to stay down.

Gastric infections are also very important, and need prompt, adequate therapy. It is simple for a baby to become dehydrated rapidly. This can become very serious if left unattended.

Any vomiting that persists for more than a few hours, or appears to be worsening, must have prompt medical help.

W is for . . .
Water
Weaning
Whooping Cough

WATER

The rate at which a baby can lose fluid especially in hot weather can be alarming. It is imperative that baby's fluid levels be maintained at all times.

Downloaded from Fountain of Knowledge Library

Many mothers do not realise how vital this is. Unless fluid is rapidly replenished, problems can arise.

Offer baby added amounts of simple, cool, boiled water on hot days. The question of how much to offer is seldom a problem. His system knows how much it needs. This will automatically be reflected in the amount he takes.

Offer him a bottle. If he completes this, and seems anxious for more, let him have a second bottle. When his system is well replenished, he will refuse any more.

A simple way of giving fluids is in the form of orange juice. (See also "Vitamins.")

Vomiting and diarrhoea are notorious for seriously and rapidly dehydrating baby.

After a few hours with these serious symptoms, baby may become perilously dehydrated. Unless fluids are replaced, an acute danger situation may arise.

Never neglect to offer baby added fluids under these circumstances. It is usually the most important part of treatment.

Offer small frequent sips of cool, boiled water. Keep repeating this, even if the vomiting persists. At least some water will be absorbed.

When there is copious diarrhoea, it is usually simpler to replace the fluids. Call the doctor if the problem persists.

WEANING

Many mothers will ask when is the best time to wean baby. There are no hard-and-fast rules.

As soon as baby can manipulate a spoon and feed himself, can manage a cup, and is taking solids in a satisfactory manner, there is no real need to continue with breast or bottle feeding.

Sometimes the choice is made for the mother. Pressure of the daily round, coping with the domestic situation (where there are often several children to look after); fatigue; chores; anxieties and tensions, can play a major part in reducing what started off as an excellent breast milk supply.

As the milk supply wanes, complement feeding must increase. This is time-consuming for the mother, and has its own problems.

Therefore, many mothers welcome the chance to get baby completely off the breast and onto a more ordinary sort of food intake.

If the mother has followed a sensible routine with the suggested educational feeding system (see "Solid Foods") little difficulty in the change-over is likely.

He will quite happily take to his new "adult" form of eating, and this can have a dramatic effect on him. He feels "grown up," and may take pride in his new-found freedom.

Of course, there will be accidents. He will make a mess, as food is often wiped over every flat surface. But little by little all this is overcome.

WHOOPING-COUGH

This is a very serious infectious disease. But fortunately, with wide use of three-in-one injections from the age of two months on, it is not so commonly seen. It attacks children chiefly under the age of one year, and in serious cases may be fatal.

It is essential that babies be given their protective immunisations early in life.

The baby receives no immunity from its mother for this disease (as it does for many others.) There is a seven- to ten-day incubation period, and the child is infectious for twenty-eight days from the start of symptoms.

A cough is often the first sign. There may be a thin, watery nasal discharge. After a few days

Be sure to keep your child immunised against the problem diseases that may crop up later in childhood.

Downloaded from Fountain of Knowledge Library

the cough becomes characteristic. It develops a paroxysmal nature. A series of short coughs in long runs takes place. Finally, the child catches his breath and takes a deep inhalation and the typical "whoop" is heard as air is sucked rapidly into the lungs.

Even children that have been immunised may still catch the disease, but it is often modified. Any persisting cough in a child may be due to this disease.

Ear infections and pneumonia may complicate the disorder. It is essential that proper medication be given. Some antibiotics can check it, provided they are given early in the course of the disease. Vomiting of the food during the cough can be a problem. Small feeds just after a vomit are often a good idea.

X is for . . . X-cellent Progress X-Rays

X-CELLENT PROGRESS

The average baby that is well nourished, and cared for with common sense and reasonable affection, will respond well.

He will grow normally, and when his progress is applied to charts and graphs, he will lie somewhere near the "norm."

This is what every parent wants to see.

At the baby health clinic, when the sister pulls out the card, mothers prefer to see their baby's graph somewhere between the upper and lower levels of normality.

A baby grows at an anticipated average rate. This applies to weight as well as height.

It can be predicted with a fair degree of certainty how long and how heavy baby will be by a given age (see "Growth rates").

How he will be reacting, what he will be saying, what sort of actions he will be making can also be predicted.

A certain number of baby illnesses are inevitable. Fortunately, he inherits a great deal of immunity to serious illnesses from his mother. So he is not likely to contract the serious infectious disorders in the first year of life.

With the use of immunisations, this resistance is greatly increased.

A sensible mother will attend to any illness at once. Simple household remedies can often be tried. If there is not a beneficial response within a short period, or baby is obviously worsening, expert medical advice is essential.

X-RAYS

Growing cells do not particularly like X-rays. For this reason, children are usually exposed to X-ray examination as infrequently as possible.

Pregnant women should not undergo X-rays unless it is essential. But few doctors will subject their pregnant patients to this form of investigation unless there is a very real need for it.

Doctors now apply the "Ten Day Rule" before X-raying women who are not taking contraceptive measures and who could possibly be pregnant. X-rays are usually limited to the first ten days of the menstrual cycle, when it is virtually certain the person is not pregnant.

This is vital in the early months of pregnancy when the baby's organs are being formed.

Foetal radiation prenatally might also increase the child's subsequent risk of developing leukaemia, again indicating the need for the utmost care with X-rays during possible pregnancy.

In some instances, it is essential for a sick child to be investigated by X-rays. Then necessity demands it, and it may be paramount to diagnosis of the complaint.

Some mothers ask if TV sets are safe. A very small amount of X-radiation occurs from a TV set, but exhaustive tests overseas indicate that the amount is minimal.

"Did you know before I was born that I was going to be a boy?"

Downloaded from Fountain of Knowledge Library

Y is for . . . Yawning

YAWNING

Babies often yawn when they are sleepy and tired. It can indicate that they are getting ready for sleep. It often seems to be a mental signal that the brain cells are in need of a rest. The body takes in a good supply of oxygen to help them recuperate more readily as a result of their rest.

Mothers are usually alert to the yawning sign, and sensible parents will take heed and get baby into a position where restful slumber is possible.

If yawning is excessive, it may indicate some underlying disability, and medical attention should be sought.

Z is for . . . Z-Z-Z-Z-Z-Z-Z Fast Asleep

Z-Z-Z-Z-Z-Z-Z FAST ASLEEP

In the days and weeks immediately following birth, baby will spend most of his time sleeping. At no time in his life will he ever again be able to enjoy so much restful slumber.

When he is awake, a lot of time may be spent crying. This is normal, and is merely his way of exercising his lungs, expanding and relaxing them, aerating his blood system. This is all part of his early days and helps to keep him fit and well.

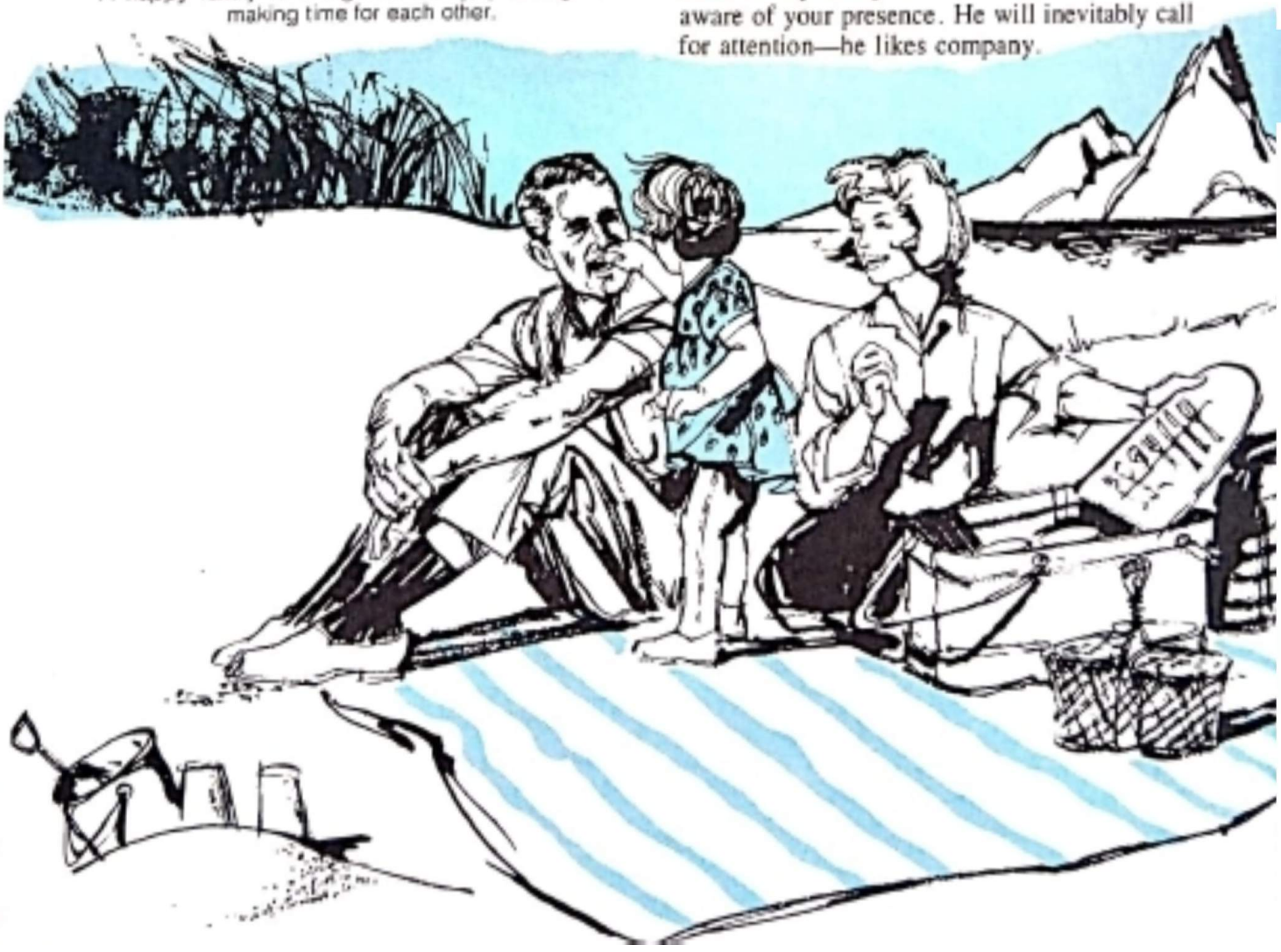
As he becomes older, his amount of sleep gradually reduces. Finally he can make do with a morning sleep only.

Later on, he may prefer to stay awake all day.

Many babies develop the habit of sleep problems at night. Too often this is initiated or aggravated by over-anxious parents.

A quiet, comfortable room and adequate bed coverings are necessary. The pre-bedtime period should be quiet, and not too mentally stimulating. It is unwise to check baby every few minutes especially if he is still awake and is aware of your presence. He will inevitably call for attention—he likes company.

A happy family is a together family, planning and making time for each other.



Downloaded from Fountain of Knowledge Library

B. A. MUJAHID BALUCH

Downloaded from Fountain of Knowledge Library

Dr. John F. Knight combines a busy suburban medical practice with regular appearances on radio and television, along with a prolific output of newspaper and magazine journalism. His message of good health and simple, sensible living has reached a world-wide audience through the agency of his twenty best-selling books.

Dr. Knight also derives professional satisfaction from his Foundation, a housing system for the aged, into which 90 per cent of his total earnings are channelled. Speaking with the warmth and sincerity of a man dedicated to his cause, the doctor declares, "I love children, young people and old people. I try to keep them all fit, well and happy." That is his continuing theme, amply demonstrated in this set of books.

ISBN 0 949809 01 2

Downloaded from Fountain of Knowledge Library